

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00897
302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

1817 Virginia Ave. Reformed Home for AgedHow long in hospital or institution? 14 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1817 - Virginia Ave.
(If rural give LOCATION)2(a) If veteran, name war None

3. (a) FULL NAME

Mamie E. Anders

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Charles Anders

7. Birth date of deceased (mo., day, yr.)

February - 27 - 1861

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

851011

hrs. min.

9. Birthplace Boonsboro Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

- None -

11. Industry or business

FATHER

12. Name

Charles Miles

13. Birthplace

Maryland

MOTHER

14. Maiden name

Sarah Nyman Miles

15. Birthplace

Maryland16. Informant Records of Reformed Church HomeAddress 1817 - Virginia Ave. Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof January - 11 - 1947
(month) (day) (year)

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

Wm. E. Baetz & Sons

Address

Boonsboro Md.

19. (Date rec'd by registrar)

Jan. 11. 1947
Black Bowers
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January - 8 - 1947 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 - 1 - 46 19 to 1 - 8 - 47 19and that I last saw her alive on 1 - 6 - 47 19

Immediate cause of death

DURATION

Due to Cardio - renalDue to Brain

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md. Date signed 1/9/47

RECEIVED

JAN 14 1947

BUREAU V 8

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....WashingtonCity or town.....Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....WashingtonCity or town.....Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No.....Pennsylvania Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

George Richard Apple

3. (b) Social Security Number

213-18-9635

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife.....Bessie Apple6.(c) If alive, give age.....43 years7. Birth date of deceased (mo., day, yr.).....October 6 1902

8. AGE: Years Months Days If less than one day

44314

.....hrs.min.

9. Birthplace.....Orleans West Virginia
(Town, county, and state)10. Usual occupation.....Guard At Fairchild11. Industry or business.....Aircraft Mfg.12. Name.....Walter Apple13. Birthplace.....Orleans WVa.14. Maiden name.....Eunici Norris15. Birthplace.....Piney Planes, Md.16. Informant.....Mrs. Bessie AppleAddress.....Hancock, Md.17. Burial Date thereof.....Jan. 23 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Cedar Grove CemeteryLocation.....Fulton County Pa.18. Funeral director.....Snyder - RowlandAddress.....Hancock, Md.19. Jan-23 47 J.H. Keller

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 20 - 47 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28 1944 to Jan. 20 1947and that I last saw him alive on Jan. 19 1947

Immediate cause of death.....

Hypernephroma - Rt. withmetastasis

DURATION

3 years

Due to.....

Due to.....

Other conditions.....None.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

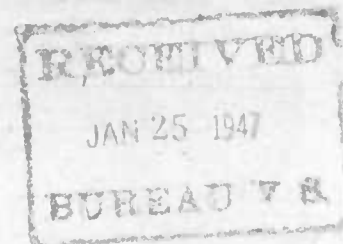
23. SIGNATURE.....Arthur Robert CohenAddress.....Ann Spring Md Date signed.....1-21-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 00899 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Died On Street
 Hospital, institution, or street address where death occurred:
N. Potomac St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Clearspring R.F.D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Broadfording Road
 (If rural, give LOCATION)
No
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Sarah Jane Bartles

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced
Widow

6. (b) Name of husband or wife Albert

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 7, 1869

8. AGE: 78 Years Months 0 Days 10 If less than one day
 hrs. min.

9. Birthplace Wilson Wash. County, Md.
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business own home12. Name Lewis Hose13. Birthplace St. Pauls, Md.14. Maiden name Lydia Vandrew15. Birthplace Williamsport, Md.16. Informant Mrs. Clyde SprinkleAddress Hagerstown, Maryland17. Burial Date thereof Jan. 20, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Broadfording CemeteryLocation Broadfording, Maryland18. Funeral director Andrew K. CoffmanAddress Hagerstown, Maryland19. Jan 20, 1947 East Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about 11 A

20. DATE OF DEATH January 17, 1947 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

acute coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results..... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

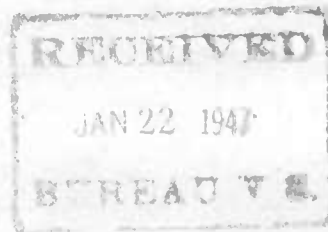
Means of injury..... Injured at work?.....

23. SIGNATURE S. Robert Muller WASH. CO., MD.Address Hagerstown, Md. M. D. 1/18/47Date signed 1/18/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Yeager
00900

192

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

930 Mulberry Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 930 Mulberry Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (a) FULL NAME

MRS. GURTRUDE BENDER

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Peter Bender

7. Birth date of deceased (mo., day, yr.) January 19, 1870 5.(c) If alive, give age — years

8. AGE: Years 77 Months 0 Days 19 If less than one day — hrs. — min.

9. Birthplace Morsbach, Colon, Germany
(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own home12. Name No Record13. Birthplace No Record14. Maiden name No Record15. Birthplace No Record16. Informant Miss Christina BenderAddress Hagerstown Md.

17. Burial Date thereof 1/30/47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffranAddress Hagerstown Md.

19. Jan. 28. 47 Charles H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1947 at 7:00 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from — 19 — to — 19 — and that I last saw him — alive on — 19 —

Immediate cause of death

Paralysis Agitans

Due to

Chronic myocarditis

Due to

Hypertensive pneumonia 24 hrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

St. Robert Wells

WASH. CO., MD.

M. D. or

Address Hagerstown, Md. Date signed 1/28/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

00901

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 43 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Wash.
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 601 W. Franklin St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Elizabeth Berger

3. (b) Social Security Number

--

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Henry Berger

6.(c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 Months Days If less than one day
 hrs. min.

9. Birthplace Martinsburg, Berkeley Co., W. Va.
 (Town, county, and state)

10. Usual occupation Housewife
 Own home

11. Industry or business

12. Name John Grozinger13. Birthplace Germany14. Maiden name Unknown15. Birthplace Germany16. Informant Mr. Henry BergerAddress Hagerstown, Md.

17. Burial Date thereof 1-21-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Scott F. Minnich & SonAddress Hagerstown, Md.

19. Jan. 21, 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 47 at 11:40p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 14, 1947 to Jan. 18, 1947
 and that I last saw her alive on Jan. 18, 1947

Immediate cause of death Carcinomatosis
 DURATION 7 months

Due to Carcinoma of Kidney Unknown

Due to

Other conditions Thyroid Adenoma 25 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

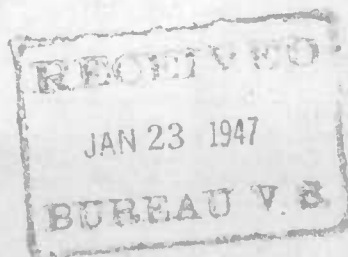
23. SIGNATURE John M. Welty, M.D.
 M. D. or other

Address Hagerstown, Md. Date signed Jan 20, 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45-15W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00902 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 months
 Hospital, institution, or street address where death occurred:
19 Mealey parkway
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 19 Mealey Parkway
 (If rural, give LOCATION)
 2(a) If veteran, name war None

3. (a) FULL NAME

MRS MARGARET ANNAN BURRILL

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Harold G.
 6. (c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) November 30 1900

8. AGE: Years 46 Months 3 Days 23 If less than one day hrs. min.

9. Birthplace Emmitsburg Frederick Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name J. Stewart Annan

13. Birthplace Emmitsburg Md.

14. Maiden name Elizabeth Morrison

15. Birthplace Emmitsburg Md.

16. Informant Harold G. Burrill

Address Hagerstown Md.

17. Burial Date thereof 1/24/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Presbyterian Cemetery

Location Emmitsburg Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Jan. 24, 47 Blasf. Bureau
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1947 at 8.15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 1946 to January 21 1947
 and that I last saw h. er alive on Tuesday Jan. 21 1947

Immediate cause of death Sarcoma of right thigh DURATION 6 mo.

Due to Pulmonary metastasis of malignancy 2 mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no autopsy Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Blasf. Bureau M. D. or other

Address 14820 Washington St. Date signed Jan 23 1947

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 27 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1228

00903

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 47 Randolph Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Howard R. Butts

3. (b) Social Security Number

220-10-3689

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Cora E. Butts

7. Birth date of deceased (mo., day, yr.) April 17, 1890 6. (c) If alive, give age years

8. AGE: Year 56 Month 8 Days 24 If less than one day hrs. min.

9. Birthplace Morgan Co., West Virginia.
 (Town, county, and state)

10. Usual occupation Employee Hag. Gas Co.

11. Industry or business

12. Name George W. Butts13. Birthplace West Virginia14. Maiden name Alice Leiter15. Birthplace West Virginia16. Informant Mrs. Cora E. ButtsAddress 47 Randolph Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 13 1947
 (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Maryland

19. Jan. 13. 47 W. H. Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10, 1947 19 10:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-6-47 to 1-10-47
 and that I last saw alive on 1-10-47 19

Immediate cause of death

DURATION

Ante-mortem obstruction

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1/14/47

MARGIN RESERVED FOR BINDING

9-45-15W

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1947

BUREAU V S

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1376

00904

3020

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 44 years
 Hospital, institution, or street address where death occurred:
425 North Potomac Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 425 North Potomac Street
 (If rural, give LOCATION)
World War I
 2. (a) If veteran, name war.

3. (a) FULL NAME

John Carmichael

3. (b) Social Security Number

705-10-4536

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Priscilla Carmichael
 6. (c) If alive, give age. years
 7. Birth date of deceased (mo., day, yr.) May 17, 1875
 8. AGE: Years 71 Months 7 Days 21 If less than one day
 hrs. min.

9. Birthplace Lexington, Virginia
 (Town, county, and state)
 10. Usual occupation Supt. of Stores
 11. Industry or business Western Maryland R.R.

12. Name John Carmichael
 13. Birthplace Savannah, Georgia
 14. Maiden name Virginia Tucker
 15. Birthplace Richmond, Virginia

16. Informant Miss Virginia Carmichael
 Address Hagerstown, Maryland
 17. Burial Date thereof 1-10-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Jan. 9, 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1947 at 6:05 PM.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 13, 1946 to Jan. 7, 1947
 and that I last saw him alive on Jan. 7, 1947
 Immediate cause of death
Hyperbrynic Azotemia
Vascular Disease
 Due to Chronic Prostatitis
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)
 Major findings of operations Chronic Prostatitis
 Date of op. Nov. 5, 1946
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. X Date of X
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE W. Howard Yeager
 Address Hagerstown, Md Date signed Jan. 8, 1947
 M. D. or other

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 11 1947
BUREAU P S

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
Hagerstown
 City or town 6 years
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
7 days
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
Hagerstown
 City or town 647 W. Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 647 W. Washington
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Clarence Charles

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

8. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

July 27, 1879

8. AGE:

Years
67Months
5Days
13If less than one day
_____ hrs. _____ min.

9. Birthplace

Charlton Wash. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

FATHER

12. Name
13. BirthplaceRudolph Charles
Charlton Md.

MOTHER

14. Maiden name
15. BirthplaceMary Davis
Clearspring Md.

16. Informant

Mrs. Garnet Gehr

Address

Hagerstown Md.

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

1-13-47

(month) (day) (year)

Cemetery or crematory

St. Pauls Cemetery

Location

Western Pike

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown Md.

19. (Date rec'd by registrar)

Jan. 13, 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1947, at 1:55 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 - 2, 1947, to 1 - 9, 1947
and that I last saw h. live alive on 1 - 9 - 47

Immediate cause of death

Pulmonary Tuberculosis

DURATION

20 yrs.

Due to

Due to

Other conditions

Benign Prostatic Hypertrophy

2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dalton M. West, M.D.

M. D. or other

Address

Hagerstown, Md.

Date signed 1-10-47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1947

F. H. A. 78

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00906 3040

1. PLACE OF DEATH:

County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 Years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Nathan Conn

3. (b) Social Security Number

NONE

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Jennie Conn
 8. AGE: Years 81 Months 5 Days 0 If less than one day _____ hrs. _____ min.
 7. Birth date of deceased (mo., day, yr.) Aug. 5 1865
 8.(c) If alive, give age 78 years

9. Birthplace Lithuania Russia
 (Town, county, and state)
 10. Usual occupation Clothing Merchant
 11. Industry or business _____
 12. Name David Conn
 13. Birthplace Russia
 14. Maiden name Bessie Balser
 15. Birthplace Russia

16. Informant Mrs. Jennie Conn
 Address Hancock, Md.
 17. Burial Date thereof Jan. 8 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore Hebrew Cemetery
 Location Belair Road Baltimore, Md.
 18. Funeral director Snyder-Rowland
 Address Hancock, Md.
 19. 1-6-47 19. J.D. Heller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1947 at 9:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1936 to 1-5 1947
 and that I last saw him alive on 1-5 1947
 Immediate cause of death Coronary Atherosclerosis
 Due to Mitral Stenosis
 Due to _____
 Other conditions Senile Debility
 (Include pregnancy within 8 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Herbert R. Zoliss
 Address Hancock, Md. Date signed 1-6-47

DURATION
12-25-76

RECEIVED

JAN 8 1947

BUREAU

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b

00907

40

Reg. Dist. No. 304

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hancock Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
Cohill Station
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Rural Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Cohill Station
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Emma Mae Conrad

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widow
 8. (b) Name of husband or wife..... Amos E. Conrad
 8. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... July 18, 1869
 8. AGE: Years..... 77 Months..... 6 Days..... 8 If less than one day..... hrs. min.

9. Birthplace..... Bedford County, Pa.
 (Town, county, and state)
 10. Usual occupation..... Home Duties
 11. Industry or business.....
 12. Name..... Harrison Clingerman
 13. Birthplace..... Belford Co., Pa.
 14. Maiden name..... Anna Leighty
 15. Birthplace..... Bedford Co., Pa.

16. Informant..... Mrs. Willa B. Purnell
 Address..... Everttville, W. Va.

17. Burial Date thereof..... Jan. 29, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Fairview Cemetery
 Location..... Route 40 W. Hancock, Md.

18. Funeral director..... Snyder-Rowland Funeral Home
 Address..... Hancock, Md.

19. 1-28-47 J. M. Veller
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 26, 1947 10:45 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
June 19 35, to 1-25 19 47
 and that I last saw her alive on 1-18 19 47

Immediate cause of death..... End-stage Renal Disease
 Due to..... Arteriosclerosis
 Due to..... Senile Debility
 Other conditions.....

(Include pregnancy within 9 months of death)

Major findings of operations.....
 Data of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury..... Injured at work?.....

23. SIGNATURE..... Herbert R. Linton M.D.
 Address..... Hancock Md. Date signed 1-27-47

BUREAU 7 6

1-52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3071

1. PLACE OF DEATH:

County Washington
 City or town Rural - Knoxville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 yrs.
 Hospital, institution, or street address where death occurred:
Rural - Knoxville, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Rural - Knoxville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Addie Elizabeth Carter Coulter

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife

Wm. J. Coulter

deceased 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec. 8, 1868

8. AGE: Years 78 Months 1 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick Co., Md.
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Berry Carter13. Birthplace Frederick Co., Md.14. Maiden name Penelope Blessing15. Birthplace Frederick Co., Md.16. Informant Father E. CoulterAddress Canton, Ohio17. Burial Jan 13, 1947

(Burial, cremation, or removal. Which?) _____ (month) (day) (year)

Cemetery or crematory Church of the BrethrenLocation Brownsville, Wash Co., Md.18. Funeral director James S. DoudaAddress 320 W Potomac St. Brunswick19. Jan 15 19 47 Bronchitis & Ascaris

(Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 19 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 14 19 46 to Jan 10 19 47and that I last saw him alive on Jan 8 19 47Immediate cause of death Pulmonary edemaDURATION 2 daysDue to Myocardial infarctiondecompensationDue to MyocardialDiabetes - AcuteSudden

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE A. J. BriceM. D. or other JeffersonAddress _____ Date signed 1/10/47

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF BURIAL OFFICIAL

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

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38. SIGNATURE OF DECEASED

39. SIGNATURE OF DECEASED

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41. SIGNATURE OF DECEASED

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44. SIGNATURE OF DECEASED

45. SIGNATURE OF DECEASED

46. SIGNATURE OF DECEASED

47. SIGNATURE OF DECEASED

48. SIGNATURE OF DECEASED

49. SIGNATURE OF DECEASED

50. SIGNATURE OF DECEASED

51. SIGNATURE OF DECEASED

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53. SIGNATURE OF DECEASED

54. SIGNATURE OF DECEASED

55. SIGNATURE OF DECEASED

56. SIGNATURE OF DECEASED

57. SIGNATURE OF DECEASED

58. SIGNATURE OF DECEASED

59. SIGNATURE OF DECEASED

60. SIGNATURE OF DECEASED

RECEIVED
JAN 20 1947
BETHESDA

1-40

2-3070-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

00909

159

Reg. Dist. No. 3820

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred: Washington County Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Big Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME James Les Cross
 4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Anna P. Cross
 6. (c) If alive, give age _____ years

3. (b) Social Security Number
705-10-5960

7. Birth date of deceased (mo., day, yr.) October 25, 1896
 8. AGE: Years 50 Months 2 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Sharpsburg, Washington, Md.
 (Town, county, and state)

10. Usual occupation Farming and Boiler Washer

11. Industry or business Western Md. Railroad

12. Name Lafayette Cross

13. Birthplace Boonsboro, Md.

14. Maiden name Lucy Scott

15. Birthplace Sharpsburg, Md.

16. Informant Mrs. Anna P. Cross

Address Big Springs, Md.

17. Burial (burial, cremation, or removal, Which?) Burial Date thereof 1/18/47
 (month) (day) (year)

Cemetery or crematory Tolson M.C. Cemetery

Location Sharpsburg, Md.

18. Funeral director William H. Dwyer

Address 291 Frederick St. Hagerstown

Jan. 8, 1947 David P. Brewer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4, 1947 at 49 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31, 1946 to Jan 4, 1947
 and that I last saw him alive on Jan 3, 1947
 Immediate cause of death _____
 DURATION _____

Cerebral Hemorrhage 5 days

Due to _____
 Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

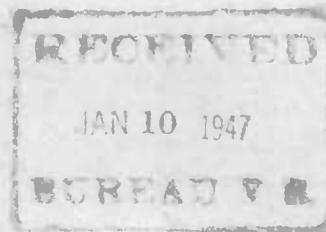
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David P. Brewer M.D.
Clear Spring Md. M. D. or other _____
 Address _____ Date signed 1/17/47



1-58

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00910

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WashingtonCity or town Rural Boonsboro
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Maurice Leslie Culler

3. (b) Social Security Number

220-16-2808

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Rosa Culler

7. Birth date of

deceased (mo., day, yr.) Feb. 21, 18826. (c) If alive, give age 60 years

8. AGE:

Years 64 Months 11 Days 5 hrs. _____ min.

9. Birthplace

Middletown Frederick Co. Md.
(Town, county, and state)

10. Usual occupation

Laborer on Railroad

11. Industry or business

FATHER

12. Name

William Culler

13. Birthplace

Middletown, Md.

MOTHER

14. Maiden name

Jennie Wiles

15. Birthplace

Middletown, Md.

16. Informant

Rosa Culler

Address

Boonsboro, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1-28-1947
(month) (day) (year)

Cemetery or crematory

Lutheran Cemetery

Location

Middletown, Md.

18. Funeral director

Gladhill Co.

Address

Middletown, Md.

19. Jan. 28, 1947

(Date rec'd by registrar)

Boonsboro
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 47 1947 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 15, 1947 to January 26, 1947and that I last saw him alive on January 26, 1947

Immediate cause of death

Coronary Thrombosis

Due to

Arteriosclerotic Tachycardia

Due to

Hypostatic Pneumonia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Boonsboro

M. D. or other

Address

Date signed

1/27/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1947

BUREAU V.B.

7-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00911

CERTIFICATE OF DEATH

Reg. Dist. No. 3050

1. PLACE OF DEATH:

County WashingtonCity or town Mapleville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Main St. at Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Mapleville
(If outside city or town limits, write RURAL and give nearest town)Street No. main st
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Robert Thomas Cunningham

3. (b) Social Security Number

- None -

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Carrie Shove Cunningham

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

December - 16 - 1879

8. AGE:

Years

Months

Days

If less than one day

67110hrs.min.9. Birthplace near Bonshoo Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Farmer and Fruit Grower

11. Industry or business

FATHER
MOTHER

12. Name

David Cunningham

13. Birthplace

Wash. Co. Md.

14. Maiden name

Helen Lynch

15. Birthplace

Wash. Co. Md.16. Informant Mrs. Carrie Cunningham

Address

Mapleville Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

January 28 1947
(month) (day) (year)

Cemetery or crematory

Bonshoo Cemetery

Location

Bonshoo Md.

18. Funeral director

Wm. J. Bast & Sons

Address

Bonshoo Md.19. Jan. 27 19 47

(Date rec'd by registrar)

John H. Bast

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 19 47 at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 26 19 47 to January 26 19 47and that I last saw her alive on January 26 19 47

Immediate cause of death

DURATION

Auricular Fibrillation

Due to

Heart Block

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury

Injured at work?

23. SIGNATURE

Wm. J. Bast & Sons

M. D. or other

Address BonshooDate signed 1/27/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 31 1947

BUREAU

1-52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Rural Big Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, institution, or street address where death occurred:
Near Big Spring
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Rural Big Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Big Spring
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Garry Robert Dick

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) Jan. 6, 1947 6. (c) If alive, give age _____ years
 8. AGE: Years -- Months -- Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Big Spring, Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Rachael Bessie Dick

15. Birthplace Clear Spring, Md.

16. Informant Rachael B. Dick

Address Clear Spring, Md. R D

17. Burial Date thereof Jan. 29-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Clear Spring, Md.

18. Funeral director Snyder-Rowland Funeral Home

Address Clear Spring, Md.

19. Jan 29 19 47 Joseph W. Murray
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1947 19 47 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6, 1947 to Jan. 27, 1947

and that I last saw him alive on Jan. 16, 1947

Immediate cause of death Premature Birth

Due to 7 1/2 mo. gestation 21 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David R. Brewer M.D. M. D. or other

Address Clear Spring Md. Date signed 1/28/47

RECEIVED

FEB 1 1947

BUREAU 8

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00913

Reg. Dist. No. 3160

1. PLACE OF DEATH: Washington
 County.....
 City or town..... Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 months & 2 days
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Juanita Delores Drury

3. (b) Social Security Number
 None

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
8. (b) Name of husband or wife.....		
8. (c) If alive, give age..... years		
7. Birth date of deceased (mo., day, yr.) April 9, 1946		
8. AGE:	Years 9	Months 2
	Days 2	If less than one dayhrs.min.

9. Birthplace. Keedysville, Wash.-Maryland
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

MOTHER	12. Name..... Paul Drury
	13. Birthplace Mercersburg-Franklin Co.-Penna
	14. Maiden name Margaret Holmes
	15. Birthplace Chestnut Grove-Wash. Co.-Md.

16. Informant..... Paul Drury
 Address..... Keedysville, Md

17. Burial..... Jan. 7-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Samples Manor

Location..... Samples Manor, Md.

18. Funeral director..... R. I. Earnshaw

Address..... Keedysville, Md

19. Jan. 7, 1947 R. I. Earnshaw
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1947, at 3:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1946, to January 5, 1947, and that I last saw her alive on January 4, 1947.

Immediate cause of death.....

Bronchitis Pneumonia

Due to Chicken Pox

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... G. W. Selway M.D.

Address..... Boonsboro Date signed Jan 5, 47

11010

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

January 8, 1947

Dear Sir:

RE:

ALFRED H. HAYES

UNITED STATES DEPARTMENT OF JUSTICE

RE:

ALFRED H. HAYES

RECEIVED
JAN 8 1947
BUREAU 86

1-50

Benjamin

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00914

CERTIFICATE OF DEATH

Reg. Dist. No. 802

1. PLACE OF DEATH:

County WASHINGTON
 City or town HAGERSTOWN R.F.D. #5
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? LIFE
 Hospital, institution, or street address where death occurred:
HAGERSTOWN R.F.D. #5
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County WASHINGTON
 City or town HAGERSTOWN R.F.D. #5
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. #5 LEITERSBURG PIKE
 (If rural, give LOCATION)
 2. (a) If veteran, name war NON-VET.

3. (a) FULL NAME

VIOLA BLANCHE ECKSTINE

3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife HOWARD J. ECKSTINE
 6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 26, 1883

8. AGE: Years 63 Months 2 Days 0 If less than one day hrs. min.

9. Birthplace R.F.D. #1, WASHINGTON, MD.
 (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name WILLIAM H. ROHRER
 13. Birthplace BEAVER CREEK, MD.
 14. Maiden name MARY ETTA FUNK
 15. Birthplace BEAVER CREEK, MD.

16. Informant William R. Eckstine
 Address Hagerstown, Irving Ave.

17. (Burial, cremation, or removal, Which?) BURIAL Date thereof Jan. 29, 1947
 (month) (day) (year)

Cemetery or crematory ROSE HILL
 Location HAGERSTOWN, MD.

18. Funeral director Woodford J. Horney
 Address Hagerstown, Md.

19. Jan. 28, 47 (Date rec'd by registrar) Registrar Chas. H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Jan 1947 at 130 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Jan 1947 to 26 Jan 1947 and that I last saw him/her alive on 25 Jan 1947

Immediate cause of death Arterio-sclerotic Cor. Vascular Disease with myocardial failure

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)
 Major findings of operations Nil Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

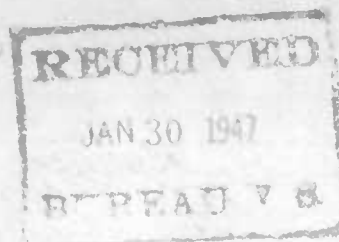
23. SIGNATURE J. J. Lush M. D. or other _____
 Address 23 N. H. Ave. Date signed 27 Jan 47

MARGIN RESERVED FOR BINDING

VS A16 9-45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Frank F. Lusk
230 N. Potomac



1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00915

Reg. Dist. No. 3020

1. PLACE OF DEATH: Washington
 County: Hagerstown
 City or town: Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 years
 Hospital, institution, or street address where death occurred:
 Washington County Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Md. County: Washington
 City or town: Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 733 S. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war: -

3. (a) FULL NAME Paynter F. Elliott
 3. (b) Social Security Number 705-10-7441

4. Sex male
 5. Color or race white
 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Rosalie Elliott

6. (c) If alive, give age: years
 7. Birth date of deceased (mo., day, yr.) June 1, 1871

8. AGE: Years 75 Months 7 Days 1 It less than one day hrs. min.

8. Birthplace Salisbury, Wicomico Co., Md.
 (Town, county, and state)

10. Usual occupation retired machinest
 11. Industry or business W. M. R. R.

FATHER 12. Name unknown
 13. Birthplace

MOTHER 14. Maiden name unknown
 15. Birthplace

16. Informant Franklin H. Elliott
 Address Hagerstown, Md.

17. burial Date thereof Jan 6, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Presbyterian Church
 Location Salisbury, Md.

18. Funeral director Scott F. Minnich & Son
 Address Hagerstown, Md.

19. Jan. 5, 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1947 at 5:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/31 1946 to 1/2 1947
 and that I last saw him alive on 1/1/47

Immediate cause of death Lobal pneumonia DURATION 5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Hornebeck M. D.

154 W. Washington St. M. D. or other

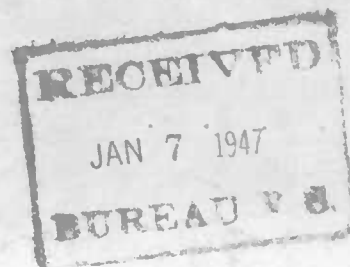
Address Hagerstown, Md. Date signed 1/3/47

MARGIN RESERVED FOR BINDING

9-45-15W

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-57

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

00916

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
City or town Funkstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Poplar Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Funkstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Poplar Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Jacob David Fisher

3. (b) Social Security Number

211-09-6176

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Nellie May Fisher

7. Birth date of deceased (mo., day, yr.) June 2, 1868 8. (c) If alive, give age 67 years

8. AGE: Years 78 Months 7 Days 28 If less than one day
hrs. min.

9. Birthplace Funkstown, Wash. Co., Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name William C. Fisher

13. Birthplace Funkstown, Maryland

14. Maiden name Caroline Gross

15. Birthplace Funkstown, Maryland

16. Informant Clyde Fisher

Address Funkstown, Maryland

17. Burial: Date thereof 2-2-47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Funkstown Cemetery

Location Funkstown, Maryland

18. Funeral director L. F. Reeher

Address Funkstown, Maryland

19. Jan. 31, 1947 Registrar East H. Hovewer

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1947 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that intended deceased from January 18, 1947 to Jan. 30, 1947

and that I last saw him alive on January 29, 1947

Immediate cause of death Cerebral hemorrhage

DURATION

4 days

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Antopsy results No autopsy Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

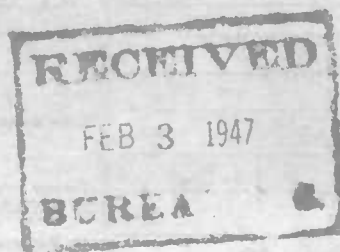
23. SIGNATURE La Bee M. D.

Address Hagerstown Md. Date signed 1/31/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-58

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

00917

CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route # 1.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ernest Albert FLOWERS

3. (b) Social Security Number

212-14-6150

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Hazel Fry Flowers

6. (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1917

8. AGE: Years 29 Months 4 Days 16 If less than one day hrs. min.

9. Birthplace Hancock, Washington County, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name John Flowers

13. Birthplace Fulton County, Pa.

14. Maiden name Jennie Brady

15. Birthplace Fulton County, Pa.

16. Informant Mrs. Lucy Mann

Address Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Jan. 30, 1947
(month) (day) (year)

Cemetery or crematory xxxxxx Rogers Heights Lutheran

Location Near Hancock, Md.

18. Funeral director Charles R. Bast

Address Hancock, Md.

19. Jan. 27, 47 (Date rec'd by registrar) Charles R. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 47, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Fractured Skull DURATION 46 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations No

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Jan. 23-47

Where did injury occur Near Hancock Wash. Ind.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) on road

Means of injury Auto accident Injured at work? No

23. SIGNATURE D. Robert Wells WASH. CO., MD.

Address Hagerstown, Md. M. D. or Jan. 27, 47

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45-15W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 29 1947

BUREAU V B

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00918

CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
City or town Hagerstown Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
Cearfoss Pike
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cearfoss Pike
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Christiana M. French

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife William H. French
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) Sept. 11, 1866
8. AGE: Years 80 Months 4 Days 14 If less than one day
..... hrs. min.

9. Birthplace Washington County, Md.
(Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business

FATHER 12. Name William E. Kline
13. Birthplace Wash. Co., Md.
MOTHER 14. Maiden name Nancy Mills
15. Birthplace Wash. Co., Md.

16. Informant William I. French
Address Hagerstown, Md. R D

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 27, 1947
(month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.

19. Jan 27, 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1947 4:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 to Jan 25 1947
and that I last saw him alive on Jan 25 1947

Immediate cause of death Chronic Myocarditis DURATION 1 yr.

Due to.....

Due to.....

Other conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of Injury Injured at work?

23. SIGNATURE W. Beachy, Jr. P. M.D. or other

Address Hagerstown, Md. Date signed Jan 25/47

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 29 1947

BUREAU 76

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00919

171

93d

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington, Co.
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Washington County Hospital
Stay in hospital or inst. (yrs., or mos., or days) 1 month
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 313 E. Third St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Annie M. Geesey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Charles E. Geesey
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) September 16, 1864

8. AGE: Years 82 Months 3 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name Daniel Sunday

13. Birthplace Frederick Co., Md.

14. Maiden name Catharine Gray

15. Birthplace Frederick Co., Md.

16. Informant Miss Beatrice T. Geesey

Address Wings Home, State Sanatorium

17. (Burial, cremation, or removal, Which?) Burial Date thereof Jan. 17, 1947

Cemetery or crematory Mt. Olivet Cem.

Location Frederick, Md.

18. Funeral director M. B. Etchison & Son

Address Frederick, Md.

19. Jan. 15, 47 Registrar Black-Brower

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1947 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1946 to Jan. 14, 1947
and that I last saw him alive on Jan. 14, 1947

Immediate cause of death Myocardial Infarction
Coronary Artery Disease
Multiple
Due to _____
Due to _____
Other conditions _____

(Include pregnancy within 8 months of death)

Major findings: none

Of operations none

Of autopsy no

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE W. Howard Yeager M. D. or other _____
Address Hagerstown, Md. Date signed Jan. 14, 1947

DURATION
1 yr +
1 yr +

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 17 1947

BUREAU V R

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

00920

Reg. Dist. No.

3031

1. PLACE OF DEATH:

County... WashingtonCity or town... Rural - near Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Gateway Nursing HomeHow long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 429 McDowell Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Geist, Ida M.

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife... John B. Geist (deceased)

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

April 20, 1864

8. AGE:

Years

Months

Days

If less than one day

82826

.....hrs.min.

9. Birthplace... Kelton, Penna.

(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

MOTHER

FATHER

12. Name... Webster Miller13. Birthplace... Pennsylvania14. Maiden name... Hannah Hall15. Birthplace... Pennsylvania16. Informant... Ross GeistAddress... Hagerstown, Md.17. Burial Date thereof... Jan. 18, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory... Rest Haven CemeteryLocation... Hagerstown, Md.18. Funeral director... L. F. ReeherAddress... Funkstown, Md.19. Jan. 17 1947 Lois M. Zickel Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 16, 1947, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 18 1946 to Jan. 15 1947
and that I last saw him alive on Jan. 15 1947

Immediate cause of death...

Chronic Valvular
Cardiac Disease
Due to Atherosclerosis
Thromboplegia

DURATION

2 yrsSame6 weeks

Due to...

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE... H. Campbell M. D. or otherAddress... Hagerstown, Md. Date signed... Jan. 17, 1947

LeRoy
Fackler
Wilson

Aug. 4058 714

145 Wilson

RECEIVED

FEB 4 1947

BUREAU 3

2-40

2-3030-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00921

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Farmersville and
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Farmersville and
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2.(a) If veteran, name war World

3. (a) FULL NAME

Eloa. May. Leonard

3. (b) Social Security Number

none

4. Sex Female 5. Color of race white 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife none
 7. Birth date 03-10-1870 deceased (mo., day, yr.)

8. AGE: Years 76 Months 7 Days - If less than one day - hrs. - min.

9. Birthplace Smithsburg and
 (Town, county, and state)

10. Usual occupation Housekeeping

11. Industry or business

12. Name Jacob Papier

13. Birthplace Smithsburg and

14. Maiden name Margaret Hooper

15. Birthplace Bedford Pa

16. Informant Viola, Farrest

Address Farmersville and

17. Burial Date thereof 1 13 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown and

18. Funeral director Aug. B. Hoover

Address Smithsburg and

19. Jan. 11. 47 Registrar East Howard

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-15-46 1946, to 1-10-47 1947, and that I last saw him alive on 1-10-47 1947.

Immediate cause of death Coronary Heart Disease DURATION 10 days

Due to arteriosclerosis

Due to arteriosclerosis

Other condition arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations arteriosclerosis

Autopsy results arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of 1-10-47

Where did injury occur? at home (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury arteriosclerosis Injured at work? no

23. SIGNATURE Dr. J. H. Hoover M. D. or other

Address Hagerstown and Date signed 1-11-47

RECEIVED

JAN 14 1947

BUREAU 78

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

★ 00922
Reg. Dist. No. 362

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
399 Liberty Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 399 Liberty Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

John Grady

3. (b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... February 9, 1868
 8. AGE: Years..... 78 Months..... 11 Days..... 11 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

12. Name..... Thomas Grady
 13. Birthplace..... Ireland
 14. Maiden name..... Catherine Lynch
 15. Birthplace..... Ireland

16. Informant..... Mrs. Katherine Ebmeyer
 Address..... Washington, D.C.

17. Burial Date thereof..... 1-22-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Jan. 21, 1947 Chas. H. Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 20, 1947 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 1, 1947 to Jan. 20, 1947
 and that I last saw him alive on Jan. 20, 1947

Immediate cause of death.....
Chronic Myocarditis
 Due to..... Atherosclerosis
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

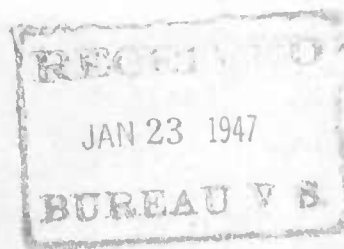
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... B. H. Hather M. D. or other
Hagerstown Date signed..... 1/21/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92~

00923

Reg. Dist. No.

3820

1. PLACE OF DEATH:

County... Washington
 City or town... Cedar Lawn, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 25 years
 Hospital, institution, or street address where death occurred:
Cedar Lawn
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Cedar Lawn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Hagerstown Route 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas W. Grosh

3. (b) Social Security Number

299-07-3437

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
<u>Male</u>	<u>White</u>	<u>Married</u>	
6.(b) Name of husband or wife... <u>Mary Grosh</u>		5.(c) If alive, give age... <u>46</u> years	
7. Birth date of deceased (mo., day, yr.) <u>August 6, 1893</u>			
8. AGE:	Years	Months	Days
	<u>53</u>	<u>5</u>	<u>6</u>
hrs.min.		

9. Birthplace... Washington County, Maryland
 (Town, county, and state)
 10. Usual occupation... District Sales Manager
 11. Industry or business... Kasco Mills Company
 12. Name... Charles L. Grosh
 13. Birthplace... Washington County, Maryland
 14. Maiden name... Alice Cook
 15. Birthplace... Clearspring, Maryland

16. Informant... Mrs. Thomas Grosh
 Address... Cedar Lawn, Maryland
 17. Burial Date thereof... 1-14-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Rest Haven Cemetery
 Location... Hagerstown, Maryland
 18. Funeral director... C. M. Suter & Sons
 Address... Hagerstown, Maryland
 19. Jan 14, 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 12 19... 47 at 12:15 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 19... 46 to Jan 12 19... 47
 and that I last saw him alive on Jan 12 19... 47
 Immediate cause of death... Cortic Stenosis
Coronary Insufficiency
 Due to...
 Due to...
 Other conditions... Acute Pulmonary Edema
Acute Left Heart Failure
 (Include pregnancy within 3 months of death)
 Major findings of operations...
 Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

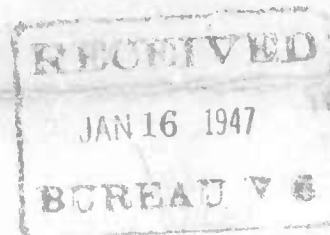
9 mos.
9 mos.

1/2 hour
12 hour

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... W. M. Suter M. D. or other
 Address... 159 W. Washington ST Date signed... 1/13/47



1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00924

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 years
Hospital, institution, or street address where death occurred:
16 Randolph Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wash.
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 Randolph Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

LeRoy Hays

3. (b) Social Security Number

--

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced

6. (b) Name of husband or wife unknown

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) September 17, 1870

8. AGE: Years 76 Months 4 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Wash. Co., Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Wilson L. Hays
13. Birthplace Frederick County, Md.

MOTHER 14. Maiden name Susanne Recher
15. Birthplace Frederick County, Md.

16. Informant Mr. Chester Hays
Address Hagerstown, Md.

17. burial Date thereof 1-24-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown, Md.

19. Jan. 24 47 Chester Hays
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1947 at 9:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 25 - 46 to Jan. 21, 47
and that I last saw him alive on Jan. 21, 47

Immediate cause of death Hypertensive Cardio-Vascular Disease DURATION 2-25-46

Due to Cardiac Failure 12-14-46

Due to Hypertensive & Renal
Other conditions Prostate 4-3-46

(Include pregnancy within 3 months of death)
Major findings of operations Resection of Prostate Date of op. 4-8-46

Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE W. Howard J. Page M. D. or other
Address Hagerstown, Md. Date signed Jan 22, 47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 27 1947

BUREAU 78

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Bell

00925

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
31 wayside Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 31 Wayside Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Mrs. / Margaret Catherine Jacobs

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

John K.

7. Birth date of

deceased (mo., day, yr.)

November 8 1875

8. AGE:

Years

Months

Days

If less than one day

71

1

23

hrs.

min.

9. Birthplace Marion Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

Conrad Peiffer

13. Birthplace

Marion Pa.

MOTHER

14. Maiden name

Susanna Wingert

15. Birthplace

Marion Pa.

16. Informant

John K. Jacobs

Address

Hagerstown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1/3/46

(month) (day) (year)

Cemetery or crematory

Long Meadows Cemetery

Location

near Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19. Jan 2, 1947

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1947 19 47 4.45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1, 1947 to Jan. 1, 1947
and that I last saw him alive on January 1, 1947

Immediate cause of death

DURATION

Cerebral hemorrhage1 day

Due to

Due to

Other conditions

Arteriosclerosis & Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

No operation

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. Bell

M. D. of other

Address

Hagerstown Md.

Date signed

1/3/47

RECEIVED

JAN 4 1947

BUREAU 18

1-50

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

93d 00926
Reg. Dist. No. 3020

1. PLACE OF DEATH: Washington
County Hagerstown
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
427 N. Jonathan Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 427 N. Jonathan
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Aaron Johnson

3. (b) Social Security Number 2

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Year 80 Months Days It less than one day hrs. min.

9. Birthplace Martinsburg, W. Va.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Seton Johnson

13. Birthplace Martinsburg, W. Va.

14. Maiden name Unknown

15. Birthplace

16. Informant James Gray

Address 427 N. Jonathan Street

17. Burial Date thereof 2/3/47
(Burial, cremation, or removal. Which?) (month, day, year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

19. Funeral director William H. Downey

Address 291 Frederick St Hagerstown

19. Feb. 3, 1947 Registrar Black/Brown
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31, 1947 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1947 to Jan 31, 1947 and that I last saw him alive on Jan 31, 1947

Immediate cause of death

Cerebrovascular

Due to Interdiction

Due to Hypertension

Other conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. B. M. D. other

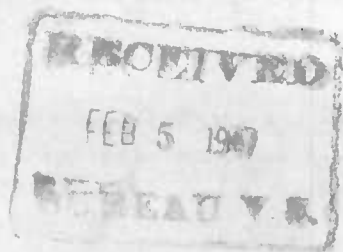
Address Hagerstown Date signed 2/17/47

DURATION
5 days
5 yrs
10 yrs
?

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-58

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00927

189

83a

Reg. Dist. No. 362

1. PLACE OF DEATH:

County WASHINGTON
City or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
301 SUMMIT AVE.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County WASHINGTON
City or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No. 301 SUMMIT AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war NONE

3. (a) FULL NAME

SARAH ALICE JONES

3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED

6.(b) Name of husband or wife IVERSON S. JONES
5.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) JULY 7, 1858

8. AGE: Years 88 Months 6 Days 18 hrs. _____ min.

8. Birthplace MAUGANSVILLE, WASH., MD.
(Town, county and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name JOHN HAUSE

13. Birthplace MARYLAND

14. Maiden name MARY MAGDALENE MAUGANS

15. Birthplace MARYLAND

16. Informant John S. Jones

Address 301 Summit Ave. City

17. BURIAL Date thereof Jan. 28, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CHURCH OF THE BRETHREN

Location BROADFORDING, MD.

18. Funeral director Woodford J. Norment

Address Hagerstown, Md.

19. Jan. 28, 1947 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1947 at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1947 to January 25, 1947
and that I last saw him/her alive on January 22, 1947

Immediate cause of death Cerebral hemorrhage

Due to _____

Due to _____

Other conditions Vascular hypertension with arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Norment M.D.

Address Hagerstown, Md. M. D. or other _____

Date signed 1/27/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1947

BUREAU V S

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Dr. Prather / 82

00928

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

240 Cypress St.How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 24 Cypress St.
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

MRS. NELLIE CAMERON KEEDY

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Martin Luther6. (c) If alive, give age ** years7. Birth date of deceased (mo., day, yr.) March 11, 1864

8. AGE:

Years 82Months 10Days 9If less than one day
--- hrs. --- min.9. Birthplace Nashville, Davidson Co., Tennessee
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own HomeFATHER 12. Name Rev. Joseph R. Stitt13. Birthplace Philadelphia Penna.MOTHER 14. Maiden name Maggie Cameron15. Birthplace Nashville Tenn.16. Informant Mrs. Mary K. FocklerAddress Hagerstown Md.17. Burial Date thereof 1/23/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Jan. 22, 47 Chas. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1947 at 11:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 1, 1931 to Jan. 20, 1947and that I last saw her alive on Jan. 20, 1947

Immediate cause of death

Cerebral hemorrhage

DURATION

1 dayA few strokes10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. Prather
Address Hagerstown Date signed 1/22/47

M. D. or other

RECEIVED

JAN 24 1947

BUREAU V. B.

1-58

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

00929

Reg. Diat. No.

3020

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred 50 W. Charles Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 50 W. Charles Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME John Foster Lake

3. (b) Social Security Number 212-14-7280

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Julia M. Lake

7. Birth date of deceased (mo., day, yr.) January 15, 1873

8. AGE: Years 73 Months 11 Days 28 If less than one day hrs. min.

9. Birthplace Pennsylvania
 (Town, County, and state)

10. Usual occupation Janitor

11. Industry or business

12. Name George Lake

13. Birthplace Pa.

14. Maiden name Mahala Aaron

15. Birthplace Pa.

16. Informant Mrs. Julia M. Lake

Address 50 W. Charles Street

17. Burial Burial Date thereof Jan. 14, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Md.

18. Funeral director William H. Downey
 Address 291 Fredrick St. Hagerstown
Jan. 14, 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1947 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Jan 10 1947

and that I last saw him alive on Jan 9 1947

Immediate cause of death Cardio-vascular Disease -

Due to

Due to

Other conditions arterio-sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. H. B. Miller
 M. D. or other
 Address 131 W. WASHINGTON, ST.
 Date signed 1947

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 16 1947

BUREAU

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Wagonsburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 1/2 months

Hospital, institution, or street address where death occurred:

1001 Hamilton Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... WashingtonCity or town... Wagonsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 1001 Hamilton Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary B. Lidy

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 10, 1872

8. AGE:

Years

Months

Days

If less than one day

74107

hrs.

min.

9. Birthplace... Waynesboro Pa.
(Town, county, and state)10. Usual occupation... Retired secretary11. Industry or business... Government Employee12. Name... Dr. Frank Lidy13. Birthplace... Franklin Co. Pa.14. Maiden name... Elizabeth Dickel15. Birthplace... Waynesboro, Pa.16. Informant... Mrs. Rose L. RinnAddress 1001 Hamilton Blvd. Wagonsburg Md.17. Burial Date thereof 1/20/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Hill CemeteryLocation Waynesboro, Pa.18. Funeral director... Walter J. HineAddress 272 Church St. Waynesboro, Pa.19. Jan 17, 47 Bliss Flowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan. 17, 1947 at 6:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 46 to Jan. 17, 1947and that I last saw him or her alive on Jan. 16, 1947Immediate cause of death... Hypertensive Cardiac-vascular Disease

DURATION

Due to... Cardiac Failure (decompensation)1 week

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations... noneDate of op. —Autopsy results... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... X Date of XWhere did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... W. Howard Yeager

M. D. or other

Address... Wagonsburg Md.Date signed Jan 17, 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 20 1947

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1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00931

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1004 The Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

John Alvey Long

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Eva Chaney Long

7. Birth date of deceased (mo., day, yr.) August - 3 - 1887

8. AGE: Years 59 Months 5 Days 3 If less than one day hrs. min.

9. Birthplace Beane Creek Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business General Construction, Road Bldg.

12. Name John W. Long

13. Birthplace Hagerstown Carroll Co. Md.

14. Maiden name Amelia Spangler Bishop

15. Birthplace Allegheny Penna

16. Informant Mrs. Eva Chaney Long

Address 1004 The Terrace, Hagerstown Md.

17. Burial Date thereof January 8, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Benevola Cemetery

Location Benevola Md.

18. Funeral director Wm J. Bad & Sons

Address Brownsville Md.

19. Jan. 7, 47 Black Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 19 47 at 2.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1939 to 1/6 19 47

and that I last saw him alive on 1/6 19 47

Immediate cause of death arteriosclerosis of the heart & coronary arteries

congestive heart failure DURATION 8 yrs

Due to congestive heart failure 6 mo.

Due to congestive heart failure

Other conditions congestive heart failure

(Include pregnancy within 8 months of death)

Major findings of operations congestive heart failure

Autopsy results congestive heart failure

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide congestive heart failure Date of 1/6/47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) congestive heart failure

Means of injury congestive heart failure Injured at work?

23. SIGNATURE John H. Hornbaker Jr. D.

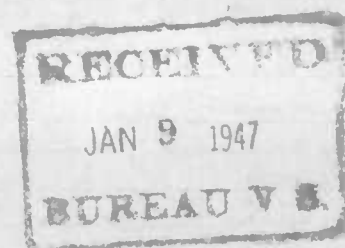
Address 104 W. Washington St. M. D. or other 1/6/47

Date signed 1/6/47

MARGIN RESERVED FOR BINDING

VS A15

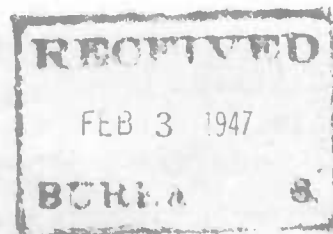
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

MARYLAND STATE DEPARTMENT OF HEALTH Dr. Hornbaker
2411 N. Charles St., Baltimore 47C ✓
CERTIFICATE OF DEATH ★ 00932 3020
Reg. Dist. No.

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>15 Years</u> Hospital, institution, or street address where death occurred: <u>121 East Lee St.</u> How long in hospital or institution? <u>--</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>121 East Lee St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>None</u>			
3. (a) FULL NAME <u>RALPH GARFIELD LUCE</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Male</u> 5. Color or race <u>White</u> 6. (a) Single, married, widowed, or divorced <u>Married</u>				MEDICAL CERTIFICATION			
6. (b) Name of husband or wife <u>Elizabeth V. Luce</u> 5. (c) If alive, give age <u>60</u> years				20. DATE OF DEATH <u>January 31, 1947</u> at <u>1 P.</u> M			
7. Birth date of deceased (mo., day, yr.) <u>March 18, 1886</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 27, 1939</u> to <u>Jan. 31, 1947</u> and that I last saw him alive on <u>Jan. 31, 1947</u>			
8. AGE: Years <u>60</u> Months <u>10</u> Days <u>11</u> If less than one day <u>--</u> hrs. <u>--</u> min.				Immediate cause of death <u>Pneumonia, carcinoma, right lung.</u> DURATION <u>about 1 1/2 yrs.</u>			
9. Birthplace <u>Springfield, Clark Co., Ohio</u> (Town, county, and state)				Due to <u>lung.</u>			
10. Usual occupation <u>Lineman</u>				Due to <u>lung.</u>			
11. Industry or business <u>--</u>				Other conditions <u>Diabetes mellitus</u> <u>about 2 yrs.</u> <u>Hypertensive Cardiovascular Disease</u> <u>8 yrs.</u> (Include pregnancy within 3 months of death)			
12. Name <u>Calvin G. Luce</u>				Major findings of operations <u>Carcinoma of right lung</u>			
13. Birthplace <u>Springfield, Ohio</u>				Date of op. <u>8/28/46</u>			
14. Maiden name <u>Elizabeth V. Starkey</u>				Autopsy results <u>PHYSICIAN: Please underline the cause to which death should be charged statistically.</u>			
15. Birthplace <u>Springfield, Ohio</u>				22. VIOLENCE: If death was due to external causes, fill in the following:			
16. Informant <u>Mrs. Elizabeth V. Luce</u>				Accident, suicide, or homicide <u>None</u> Date of <u>None</u>			
Address <u>Hagerstown Md.</u>				Where did injury occur? (City or town) (County) (State)			
17. Burial <u>Green Hill Cemetery</u> Date thereof <u>2/3/47</u> (Burial, cremation, or removal. Which?) (month) (day) (year)				Injured at home, farm, industry, public place (where?)			
Cemetery or crematory <u>Berryville Virginia</u>				Means of injury <u>None</u> Injured at work?			
18. Funeral director <u>Andrew K. Coffman</u>				23. SIGNATURE <u>John H. Hornbaker M.D.</u>			
Address <u>Hagerstown Md.</u>				154 W. Washington St. M. D. or other			
19. (Date rec'd by registrar) <u>Jan. 31, 1947</u> <u>Chas. H. Bowers</u> Registrar				Address <u>Hagerstown, Md.</u> Date signed <u>1/31/47</u>			



1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00933

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 Years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 221 W Howard St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Samuel Mathna

3. (b) Social Security Number

219-12-1903

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Florence Mathna

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1886
 6. (c) If alive, give age

8. AGE: Years 60 Months 4 Days 3 It less than one day
 hrs. min.

9. Birthplace Franklin County, Pa.
 (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

12. Name John Mathna13. Birthplace Penna.14. Maiden name Martha McClinic15. Birthplace Penna.16. Informant Mrs. Florence MathnaAddress 221 W. Howard St. Hagerstown, Md.

17. Burial Date thereof Jan. 19, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.

19. Jan. 18, 47 Chas. H. Flowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16, 1947 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4, 1947 to Jan 16, 1947
 and that I last saw him Jan 16, 1947 alive on Jan 16, 1947

Immediate cause of death Coronary thrombosis
 DURATION 2 wks.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dr. Beasley M.D.Address Hagerstown, Md. Date signed Jan 16/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 21 1947

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1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

00934

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Washington Co. Jail
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 129 Elm St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

JOHN ARLINGTON McCURDY

3. (b) Social Security Number

213-16-1350

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife Lula McCurdy
 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) December 16, 1898

8. AGE: Years 48 Months 0 Days 27 (If less than one day) _____ hrs. _____ min.

9. Birthplace Mc Connellsburg Fulton Co. Pa.
 (Town, county, and State)

10. Usual occupation Laborer

11. Industry or business Statton Furniture Co.

12. Name Charles McCurdy

13. Birthplace McConnellsburg Pa.

14. Maiden name Etta Suter

15. Birthplace McConnellsburg Pa.

16. Informant Mrs Lula McCurdy

Address Hagerstown Md.

17. Burial Date thereof 1/15/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Jan. 18, 47 Charles H. Howard
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1947 at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____

Acute coronary occlusion

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.

Address Hagerstown, Md. WASH. CO. MD.
 M. D. 1/14/47

Date signed 1/14/47

RECEIVED

JAN 17 1947

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

00935

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
2102 Lexington Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residences of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2102 Lexington Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Levi Edward Moore

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) October 15, 1870

8. AGE: Years 76 Months 3 Days 7 If less than one day
hrs. min.

9. Birthplace Mooresville, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business

12. Name Isaac Moore
13. Birthplace Mooresville, Maryland

14. Maiden name Matilda Mills
15. Birthplace Parkhead, Maryland

16. Informant Shelton Hetzer
Address Hagerstown, Maryland

17. Burial Date thereof 1-25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland
C. M. Suter & Sons

18. Funeral director Hagerstown, Maryland
Address

19. Jan. 24, 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1947 at 5:45 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 1937 to Jan. 22, 1947
and that I last saw him alive on Jan. 22, 1947

Immediate cause of death Arteriosclerosis DURATION 10 yrs +

Due to
Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X X X Date of X

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Howard Page M. D. or other

Hagerstown, Md Date signed Jan. 23, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 27 1947

BUREAU

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

00936

CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Route # 11 at city limits
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Washington County Home
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charles Webster Morningstar

3. (b) Social Security Number
None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) March 29, 1874

8. AGE: Years 72 Months 9 Days 6 If less than one day
 hrs. min.

9. Birthplace Union Bridge, Maryland
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Joseph K. Morningstar

13. Birthplace Maryland

14. Maiden name Mary Ellen Saylor

15. Birthplace Maryland

16. Informant Mrs. Evelyn E. Harmison

Address Reading, Pa.

17. Burial Date thereof Jan. 7, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Jan. 7, 1947 Registrar Robert Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

Jan. 4 1947 5:30P

20. DATE OF DEATH 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 to 19

and that I last saw him alive on 19

Immediate cause of death.....

DURATION

open fracture of skull

Due to.....

closed fracture of left

Due to.....

open fractures of rt & left

Other conditions.....

tibias & fibulae

hemorrhage & shock
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of Jan/4/47

Where did injury occur? Hagerstown Wash, Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where) Middleburg Pike

Means of injury struck by auto Injured at work?

23. SIGNATURE.....

Address.....

Date signed 1/6/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 9 1947

BUREAU V S

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Entire LifeHospital, institution, or street address where death occurred:
316 N. Cannon Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 316 N. Cannon Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Helen Corinne Mowen

3.(b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 19128. AGE: Years 34 Months 9 Days 18 If less than one day
.....hrs.min.9. Birthplace Hagerstown, Washington Co., Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Adam LeRoy Mowen13. Birthplace Hagerstown, Md.14. Maiden name Elizabeth Helen Smith15. Birthplace Oskaloosa, Iowa16. Informant E. Helen MowenAddress 316 N. Cannon Ave.17. Burial Date thereof Jan. 25, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director L. F. ReecherAddress Funkstown, Md.19. Jan. 24, 1947 Registrar Charles Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 1947 at 10:28 P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
1947 to 1/21 1947and that I last saw her alive on 1/21 1947Immediate cause of death multiple sclerosis -

DURATION

12-15yearsDue to (?)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations 0

Date of op.

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 0 Date ofWhere did injury occur? 0
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ✓ Injured at work?V. Victor D. Miller23. SIGNATURE V. Victor D. MillerAddress 131 W. WASHINGTON ST.

M. D. or other

Date signed 1/22/1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 27 1947

BUREAU 7 &

1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157g * 00938 3030

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 10 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Clear Spring, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ronald Lee Mummert

3. (b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... Jan. 16, 1947
 8. AGE: Years..... 0 Months..... 0 Days..... 10
 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown - Wash. Md.
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

12. Name..... Lawrence M. Mummert
 13. Birthplace..... Welsh Run, Pa.

14. Maiden name..... Gladys Myers
 15. Birthplace..... Clear Spring, Md.

16. Informant..... Lawrence M. Mummert
 Address..... Clear Spring, Md.

17. Burial..... Date thereof..... Jan. 26, 1947
 (Burial, cremation, or removal, Which?)..... (month) (day) (year)

Cemetery or crematory..... St. Paul's Cemetery
 Location..... Near Clear Spring, Md.

18. Funeral director..... Fred W. Kraiss
 Address..... Hagerstown, Md.

19. Jan 26 47..... Joseph M. Mummert
 (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 26, 1947 1947 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 16, 1947 to Jan 26, 1947
 and that I last saw him alive on Jan 25, 1947

Immediate cause of death.....
Malformation of Small Intestine
 Due to..... Jejunum - Absent
 Due to.....

Other conditions.....

(Include pregnancies within 3 months of death)
 Major findings of operations..... Laparotomy Done -
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... David R. Brewer M.D.
 Address..... Clear Spring Md. M. D. or other.....
 Date signed..... 1/26/47

RECEIVED
FEB 1 1947
BUREAU V B

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

00939

★ Reg. Dist. No. 3030

196

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, R.F.D. 4
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 50 Years
 Hospital, institution, or street address where death occurred:
Cearfoss, Md.
 How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Cearfoss,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cearfoss & Broadfording, Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3. (a) FULL NAME

Lewis Franklin Murrey

3. (b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widower
 6.(b) Name of husband or wife..... Ella
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... February 5, 1864
 8. AGE: Years..... 82 Months..... 11 Days..... 24 It less than one day..... hrs. min.

9. Birthplace..... Cearfoss, Washington Co., Md.
 (Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business..... Retierd

FATHER 12. Name..... John Murrey
 13. Birthplace..... Cearfoss, Maryland

MOTHER 14. Maiden name..... Susan Mower
 15. Birthplace..... Cearfoss, Maryland.

16. Informant..... John W. Palmer
 Address..... Hagerstown, R.#4

17. Burial Date thereof..... Jan. 37/47
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Broadfording, Cemetery
Broadfordind, Maryland
 Location.....

18. Funeral director..... Andrew K. Coffman
 Address..... Hagerstown, Maryland

19. Jan. 30. 19 47 Blasfowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 29, 1947 at 10:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-10-46 1946 to Jan 29-47 1947
 and that I last saw him alive on Jan 28-47 1947

Immediate cause of death..... Ch. Myocarditis DURATION..... 3 days

Due to..... Ch. Myocarditis

Due to..... Ch. Myocarditis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

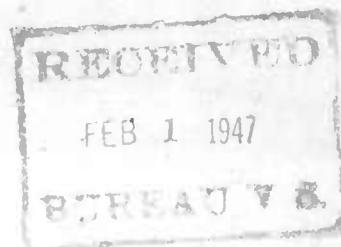
Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W. C. H. H. H. M. D. or other

Address..... Hagerstown, Md. Date signed..... 2/2/47



1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00940

Reg. Dist. No. 3820

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month
 Hospital, institution, or street address where death occurred:
1723 Virginia Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Penna. County Montour
 City or town Danville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Bloom Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war NON-VET.

3. (a) FULL NAME

ANNA BIRK OLSEN

3. (b) Social Security Number

NONE4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Lawrence Olsen6. (c) If alive, give age 82 years7. Birth date of deceased (mo., day, yr.) May 26, 18678. AGE: Years 79 Months 7 Days 5 If less than one day hrs. min.9. Birthplace Denmark
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Christian Birk13. Birthplace Denmark14. Maiden name Katrina Sorensen15. Birthplace Denmark16. Informant X Lawrence OlsenAddress Denville Penna.17. Funeral (Burial, cremation, or removal. Which?) Date thereof Jan. 3, 1947
(month) (day) (year)Cemetery or crematory Rest HavenLocation Hagerstown, Md.18. Funeral director Woodford J. NormanAddress Hagerstown, Md.19. Jan. 3, 1947 (Date rec'd by registrar) Breast Bowens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 19 47 at 11 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 19 46 to Jan 1 19 47and that I last saw him alive on Jan 1 19 47Immediate cause of death Cancer - Vesiculardisease - HemiplegiaDURATION 6 daysDue to arterio-sclerosis of heart

Due to

Other conditions Carcinoma of right breast

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

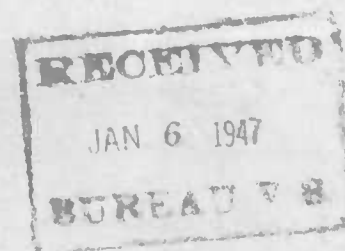
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. Campbell M. D. or otherAddress 145 N. Washington St. Date signed Jan 2, 1947



1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00941

195

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town St James, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Evelynne Richardson Onderdonk

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Adrian H. Onderdonk
 6.(c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) August 24, 1887
 8. AGE: Years 59 Months 5 Days 3 If less than one day
hrs.min.

9. Birthplace Middletown, Conn.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business

FATHER 12. Name Dr. William C. Richardson
 13. Birthplace Auburn, New York
 MOTHER 14. Maiden name Maude Stanley
 15. Birthplace Auburn, New York

16. Informant Adrian Onderdonk, Jr.
 Address St. James, Maryland
 17. Burial 1-29-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Marks Cemetery
Lappans, Maryland
 Location

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Jan. 29, 47 Blair Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 19 47 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 3 19 47 to Jan 27 19 47
 and that I last saw her alive on Jan 26 19 47

Immediate cause of death Myocardial Failure
 DURATION 24 days

Due to Arteriosclerotic Heart Disease

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Robert V. P. Campbell M.D.
 M. D. or other
 Address Hagerstown Md. Date signed Jan 28/47

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JAN 31 1947

BUREAU OF

1-52

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00942

CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County..... Washington
 City or town..... Funkstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Wash.

City or town..... Funkstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

John C. O'Neal

3. (b) Social Security Number

4. Sex..... male
 5. Color or race..... white
 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Emma Florence O'Neal

6. (c) If alive, give age..... 75 years

7. Birth date of deceased (mo., day, yr.)..... July 24, 1876

8. AGE: Years..... 70 Months..... 5 Days..... 26
 If less than one day..... hrs. min.

9. Birthplace..... Boonsboro, Wash. Co., Md.
(Town, county, and state)

10. Usual occupation..... Printer

11. Industry or business..... U. S. Government

12. Name..... Joseph O'Neal

13. Birthplace..... Unknown

14. Maiden name..... Clara Keedy

15. Birthplace..... Unknown

16. Informant..... Mrs. Emma O'Neal

Address..... Funkstown, Md.

17. burial Date thereof..... 1-22-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Boonsboro Cemetery

Location..... Boonsboro, Md.

18. Funeral director..... Scott F. Minnich & Son

Address..... Hagerstown, Md.

19. Jan. 22, 47 Date rec'd by registrar.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 20, 1947, at 7:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 20 1947

and that I last saw him alive on Jan 20 1947

Immediate cause of death.....

Carcinoma of Prostate 3 yrs

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Andrew Novitsky M.D.

Address..... M. D. or other

Date signed..... 1/21/47

MARGIN RESERVED FOR BINDING

VS A15

9-43-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 24 1947

BUREAU

1-58

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3070

1. PLACE OF DEATH

County Washington
City or town Rohersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution or street address where death occurred:
Rohersville Md.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Rohersville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rohersville Md.
(If rural, give LOCATION)
2(a) If veteran, name war None

3. (a) FULL NAME

Lulu Mary Potter

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Herbert R. Potter
7. Birth date of deceased (mo., day, yr.) February - 5 - 1877 6. (c) If alive, give age _____ years
8. AGE: Years 69 Months 11 Days 20 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25th 1947 at 9:20 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11th 1938 to Jan 25th 1947
and that I last saw him alive on Feb. 3rd 1947

Immediate cause of death Chronic myocarditis

DURATION

8 years

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of Injury _____ Injured at work? _____

23. SIGNATURE Stuart Wade, Jr. M.D.
Address 1300 S. 1st St. Md. Date signed 1/27/47

9. Birthplace Rohersville Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business Own Home
12. Name Millard J. Clapper
13. Birthplace Rohersville Wash. Co. Md.
14. Maiden name Susan Huffer
15. Birthplace Rohersville Wash. Co. Md.
16. Informant Mrs. John Keedy
Address Rohersville Md.
17. Burial Date thereof Jan. 28, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rohersville Cemetery
Location Rohersville Md.
18. Funeral director Wm. J. Best & Sons
Address Boonsboro Md.
19. Jan 27 1947 Miss Catherine J. Spangler
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P.R. Wade

RECEIVED
FEB 6 1947
BUREAU V E.

2-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66944

Reg. Dist. No. 3050

1. PLACE OF DEATH:

County Washington
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months
 Hospital, institution, or street address where death occurred:
711 Main St.
 How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Cumberland
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Mechanicsburg R. 4
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Benjamin Franklin

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Alie - 2

7. Birth date of deceased (mo., day, yr.) September 14 - 1868

8. AGE: Years 78 Months 4 Days 1 If less than one day

9. Birthplace Wormleysburg, Penna.
 (Town, county, and state)

10. Usual occupation Car Inspector (Retired)

11. Industry or business Penna R. R. Co.

12. Name William Rapp

13. Birthplace near Reading Penna.

14. Maiden name Catherine J. Fortney

15. Birthplace Harrisburg Penna.

16. Informant Mrs. Nora Sparrow

Address Bethesda Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof January 18, 1947
 (month) (day) (year)

Cemetery or crematory Camp Hill Cemetery

Location Camp Hill Penna.

18. Funeral director Wm. J. Bart & Sons

Address Bethesda Md.

19. Date rec'd by registrar January 16, 1947 Registrar John L. Bart

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 15 1947 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Jan 15 1947

and that I last saw him alive on January 15 1947

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Lellan M.D.

Address Bethesda Date signed 1/15/47

RECEIVED

JAN 18 1947

BUREAU OF

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

00945

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown R # 5
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 Years
 Hospital, institution, or street address where death occurred:
Beards Church Road
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R # 5
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Beards Church Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

MRS MAUDE MINNICH REYNOLDS

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Kemp
 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) June 21 1874
 8. AGE: Years 62 Months 2 Days 23 If less than one day hrs. min.

9. Birthplace Waynesboro Franklin Co. Pa.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home

12. Name Jacob minnich
 13. Birthplace Waynesboro Pa.
 14. Maiden name Mary Ruthraff
 15. Birthplace Greensburg Md.

16. Informant Mr. Kemp Reynolds
 Address Hagerstown Md. R # 5

17. Burial Date thereof 1/17/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Millers Mennonite Cemetery
 Location near Leitersburg Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Jan. 16. 47 Chas. H. Flowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1947 19 11.55 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 to 19 and that I last saw him alive on 18

Immediate cause of death Acute Coronary Occlusion
 Due to Coronary Occlusion 1/15/46

Due to Coronary Occlusion
 Other conditions None

(Include pregnancy within 3 months of death)
 Major findings of operations None Date of op. None
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dr. Robert H. Wells DEPUTY MEDICAL EXAMINER
 Address Hagerstown, Md. WASH. CO., MD.
 Date signed 1/15/47

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 18 1947

BUREAU OF

1-57

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

CERTIFICATE OF DEATH

009463020
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Leesburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Big Pool Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Park Head Dist.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Joseph Ridenour

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sarah Belle Ridenour
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 15, 1870
 8. AGE: Year 76 Months 3 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Farming
 11. Industry or business

12. Name Unknown Ridenour
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Mrs. Sarah Belle Ridenour
 Address Big Pool, Md. R F D

17. Burial Date thereof Jan. 30, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Paul's Cemetery
 Location Route 40 Near Clear Spring, Md

18. Funeral director Snyder-Rowland Funeral Home
 Address Clear Spring, Md.

19. Jan. 31, 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1947 12:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17 to Jan. 27 and that I last saw him alive on Jan. 27

Immediate cause of death Prostatic hypertrophy
Benign

Due to Malnutrition
 Due to

Other conditions

(Include pregnancy within 3 months of death)
 Major findings of operations Prostatic hypertrophy
None Date of op. 12-30-46

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of _____
 Where did injury occur? (City or town) (County) (State)

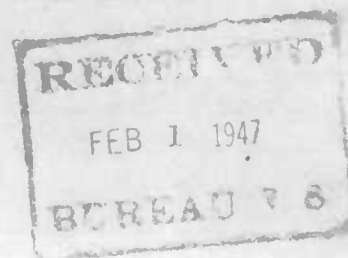
Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

SIGNATURE Arthur Robert Cohen M. D. Registrar
 Address Clear Spring, Md Date signed 1-28-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

 00947-3040
 Reg. Diat. No.

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Hancock</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>20 Years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Hancock</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Frances Gorden Rider</u>				3. (b) Social Security Number <u>NONE</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Widowed</u>		MEDICAL CERTIFICATION	
6.(b) Name of husband or wife <u>Charles T. Rider</u>				20. DATE OF DEATH <u>Jan 4</u> 19 <u>46</u> at <u>4:30</u> <u>A</u>			
7. Birth date of deceased (mo., day, yr.) <u>Aug. 23 1862</u>				21. I CERTIFY that death occurred on the date above stated, that I attended deceased from <u>Dec 28</u> 19 <u>46</u> to <u>Jan 4</u> 19 <u>47</u> and that I last saw him..... alive on <u>Jan 3</u> 19 <u>47</u>			
8. AGE: Years..... <u>84</u>		Months..... <u>4</u>		Days..... <u>2</u>		If less than one day..... hrs. min.	
9. Birthplace <u>Rockingham Co. Va.</u> (Town, county, and state)				Immediate cause of death <u>Cerebral hemorrhage</u>			
10. Usual occupation <u>Home Work</u>				Due to <u>Hypertension</u>			
11. Industry or business				Due to <u>Chronic Myocard.</u>			
12. Name <u>John W. Rider</u>				Other conditions			
13. Birthplace <u>Not Known</u>				(Include pregnancy within 3 months of death)			
14. Maiden name <u>Amanda Keezel</u>				Major findings of operations			
15. Birthplace <u>Not Known</u>				Date of op.....			
16. Informant <u>Mrs. Annabell Miller</u>				Autopsy results			
Address..... <u>Hancock, Md.</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial <u>Green Way Cemetery</u>				22. VIOLENCE: If death was due to external causes, fill in the following:			
Date thereof..... <u>Jan. 7 1947</u> (Burial, cremation, or removal. Which?) (month) (day) (year)				Accident, suicide, or homicide..... Date of.....			
Cemetery or crematory..... <u>Berkeley Spring Wva.</u>				Where did injury occur?..... (City or town) (County) (State)			
Location.....				Injured at home, farm, industry, public place (where?).....			
18. Funeral director <u>Snyder-Rowland</u>				Means of injury..... Injured at work?.....			
Address..... <u>Hancock, Md.</u>				23. SIGNATURE <u>W. H. Shaffer MD</u>			
19. 1-6-47				M. D. or other.....			
(Date rec'd by registrar)				Address..... <u>Hancock, Md.</u> Date signed..... <u>1/6/47</u>			
Registrar..... <u>John H. Vetter</u>							

RECEIVED
JAN 8 1947
BUREAU OF

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

CERTIFICATE OF DEATH

00948

Reg. Dist. No. 3160

1. PLACE OF DEATH:

County... Washington
 City or town... Rural--Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 71 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Wash.
 City or town... Rural--Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Jacob Moody Rohrer

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 20 1947 at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 8 1947 to Jan 20 1947
 and that I last saw him alive on Jan 19 1947

Immediate cause of death

Chronic Myocarditis

DURATION

8 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Data signed

6. (b) Name of husband or wife Charlotte (Grove) Rohrer

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 31, 1875

8. AGE:

Years

71

Months

2

Days

20

If less than one day

hrs. min.

9. Birthplace

Eakles Mill-Wash.-Md
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name

Jacob C. Rohrer

13. Birthplace

Rohrersville, Md

MOTHER

14. Maiden name

Barbara Wyand

15. Birthplace

Eakles Mill, Md

16. Informant

Mrs. C. Grove Rohrer

Address

Keedysville, Md

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 22--1947
(month) (day) (year)

Cemetery or crematory

Rohrersville

Location

Rohrersville, Md.

18. Funeral director

R. I. Earnshaw

Address

Keedysville, Md

19.

Jan 23 1947
(Date rec'd by registrar)

Registrar

RECEIVED
JAN 27 1947
BUREAU V.E.

1-58

RAD CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00949

173

83a

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hotel Patterson, 100 N. Pot. St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

William U. Roulette

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Elizabeth Roulette
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) January 27, 1878
 8. AGE: Years 68 Months 0 Days 12 If less than one day..... hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Retired Manufacturer
 11. Industry or business.....

FATHER 12. Name Joseph C. Roulette
 13. Birthplace Hagerstown, Maryland
 MOTHER 14. Maiden name Lavinia K. Updegraff
 15. Birthplace Hagerstown, Maryland

16. Informant George Updegraff
 Address Hagerstown, Maryland
 17. Burial Date thereof 1-17-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Jan. 16 1947 Blair H. Bowers
 (Date rec'd by registrar) Registrar

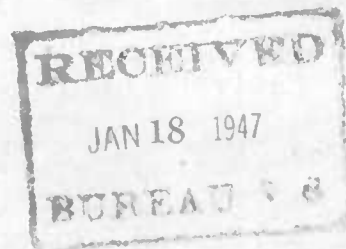
MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1947 at 2:40 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1947 to Jan. 15, 1947
 and that I last saw him/her on January 15, 1947
 Immediate cause of death Cerebral Hemorrhage DURATION 36 hours
 Due to.....
 Due to.....
 Other conditions Atherosclerosis
 (Include pregnancy within 3 months of death)
 Major findings of operations None Date of op.
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE R. B. B. M. D. another
 Address Hagerstown Md. Date signed 1/16/47



1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00950305

1. PLACE OF DEATH:

County Washington
City or town Mt. Lema
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
Boonsboro Md. R. 2
How long in hospital or Institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Mt. Lema
(If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

Mary Katherine Routzahn

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Clyde M. Routzahn
6. (c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) June - 3 - 1892
8. AGE: Years 54 Months 7 Days 8 If less than one day hrs. min.

9. Birthplace Mt. Lema Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name John Reese

13. Birthplace Mt. Lema Wash. Co. Md.

14. Maiden name Eliza Saunders

15. Birthplace Mt. Lema Wash. Co. Md.

16. Informant Clyde M. Routzahn

Address Boonsboro Md. R. 2

17. Burial Date thereof Jan - 14 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church of the Brethren Cemetery

Location Beaver Creek Md.

18. Funeral director Wm. J. Battsous

Address Boonsboro Md.

19. Jan 12 19 47 John L. Battsous
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1946 to Jan 11 1947

and that I last saw him Jan 11 1947 alive on Jan 11 1947

Immediate cause of death Pulm. Emphysema Rhs

Due to Generalized Arterio-sclerosis

Due to Generalized Arterio-sclerosis

Other conditions 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Antopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Meane of injury None Injured at work? None

23. SIGNATURE J. G. Koller M. D. or other None

Address San Antonio Date signed Jan 11 1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 15 1947
BUREAU V B

1-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

193

00951

13a

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 22 Years
 Hospital, institution, or street address where death occurred:
847 W. Washington St.
 How long in hospital or institution?... --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 847 W Washington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

Abram Clinton Ruth

3. (b) Social Security Number

705-10-S383.

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Married

6. (b) Name of husband or wife... Irene
 6. (c) If alive, give age... 63 years

7. Birth date of deceased (mo., day, yr.)... September 10, 1876

8. AGE: Years... 70 Months... 4 Days... 17 If less than one day... --- hrs. --- min.

9. Birthplace... Maugansville Washington Co., Md.
 (Town, county, and state)

10. Usual occupation... Railway Conductor

11. Industry or business... Western Maryland

12. Name... B. Franklin Ruth

13. Birthplace... Maugansville Md.

14. Maiden name... Fianna Hunsberger

15. Birthplace... Ephrata Pa.

16. Informant... Mrs Irene Ruth
 Address... Hagerstown Md.

17. Burial... Reed Haven Cemetery
 (Burial, cremation, or removal. Which?) Date thereof... 1/29/47
 (month) (day) (year)

Cemetery or crematory... Hagerstown Md.

Location... Hagerstown Md.

18. Funeral director... Andrew K. Coffman

Address... Hagerstown Md.

19. Jan. 28, 47 Charles Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 27, 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 17, 37 to Jan. 27, 47 and that I last saw him alive on Jan. 27, 47

Immediate cause of death... Vascular Hypertension

DURATION

10 yrs

Due to... Prostatic Hypertrophy

(Benign)

Due to... Chr. interstitial nephritis

8 yrs

Uremia

3 days

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations... None

Date of op.

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... No Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... S. Robert Wells M.D.

Address... Hagerstown, Md. Date signed... 1/28/47

RECEIVED

JAN 30 1947

BUREAU V B.

1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01044

552

B 000

1. PLACE OF DEATH:

County... Washington
 City or town... Rural--Sharpsburg, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 26 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Wash.
 City or town... Rural-Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war... War 1 with England

3. (a) FULL NAME

John Thomas Sadler

3. (b) Social Security Number

220- 16- 3733

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Married

B. (b) Name of husband or wife... Ruth (Breeze) SadlerB. (c) If alive, give age... 53 years7. Birth date of deceased (mo., day, yr.)... Oct. 31, 1889

8. AGE: Years... 57 Months... 2 Days... 15 It less than one day
 ...hrs. ...min.

9. Birthplace... Kidderminster-Worcester-England
 (Town, county, and state)10. Usual occupation... Stock room clerk11. Industry or business... Victor Products-Hagerstown, Md12. Name... John T. Sadler13. Birthplace... England14. Maiden name... Unknown15. Birthplace... "16. Informant... Mrs. Ruth SadlerAddress... Harpers Ferry R. F. D. #117. Burial Date thereof... Jan 18, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Mt. ViewLocation... Sharpsburg, Md18. Funeral director... R. I. EarnshawAddress... Keedysville, Md

19. Jan 17 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan. 15 1947 at 10: P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 13 1947 to January 15 1947
 and that I last saw him alive on January 13 1947

Immediate cause of death... Carcinoma of maxillary sinoids. DURATION... 10 mon.

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... G. W. Boyce M. D.Address... Bonnsboro Date signed... 1/17/47

RECEIVED

FEB 26 1947

BUREAU V B

2-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107

00952

Reg. Diat. No. 3160

1. PLACE OF DEATH:

County Washington
 City or town Rural Keedysville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Washington
 City or town Rural Keedysville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

George William Sheffer Jr.

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 19468. AGE: Years 0 Months 2 Days 15 If less than one day _____ hrs. _____ min.9. Birthplace Hagerstown, Washington Co., Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name George W. Sheffer13. Birthplace Middletown, Md.14. Maiden name Arbutus E. Sweeney15. Birthplace Keedysville, Md.16. Informant George W. ShefferAddress Keedysville, Md.17. Burial Date thereof 1-19-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran CemeteryLocation Middletown, Md.18. Funeral director Gladyhill Co.Address Middletown, Md.19. Jan 18 19 47 Relucting
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 19 47 at 3:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 47 to Jan 18 19 47 and that I last saw him alive on Jan 17 19 47

Immediate cause of death _____

DURATION

Bronchial Pneumonia 3 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. S. Hays MD M. D. or other _____Address Middletown Md. Date signed 1-18-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
729 Salem Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 729 Salem Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Max George Sibert

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Jessie I. Sibert
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) May 28, 1890
8. AGE: Years 56 Months 7 Days 30 If less than one day _____ hrs. _____ min.

9. Birthplace Cearfoss, Washington Co., Md.
(Town, county, and state)

10. Usual occupation Retired R.R. Conductor

11. Industry or business

12. Name Lewis E. Sibert
13. Birthplace Maryland
14. Maiden name Nellie Cearfoss
15. Birthplace Maryland

16. Informant Mrs. Max G. Sibert
Address 729 Salem Ave. Hagerstown, Md.

17. Burial Burial Date thereof Jan. 29, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland.

18. Funeral director Fred W. Kraiss
Address Hagerstown, Maryland.

19. Jan. 29, 47 Registrar Blanch Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1947 19 5:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-46 19 to 1-27-47 19
and that I last saw him alive on 1-26-47 19

Immediate cause of death Cerebral Hemorrhage DURATION 4 days
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE W. E. Bowers M. D. or other _____
Address Hagerstown, Md. Date signed 1-27-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12830

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

STATION WORKSHEET

ALBANY, N.Y.

APPROVED BY

RECEIVED
JAN 31 1947
BUREAU V B

1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00954

CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? while at work
 Hospital, institution, or street address where death occurred:
Fairchild Aircraft Plant 2
 How long in hospital or institution? 1 at work

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Mount Grove P. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Kedysville Ind R. 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war 110

3. (a) FULL NAME

John Elmer Smith

3. (b) Social Security Number

213-12-7221

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ruelle Smith
 7. Birth date of deceased (mo., day, yr.) December 21-1894
 8. AGE: Years 52 Months 1 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace near Kedysville Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Pilot Chaser

11. Industry or business Fairchild Aircraft Corp.

12. Name Esage Smith

13. Birthplace Kedysville Wash. Co. Md.

14. Maiden name Emma Sigler

15. Birthplace near Huddelltown Ind. Co. Md.

16. Informant Mrs. Ruelle Smith

Address Kedysville Ind. R. 1

17. Burial Date thereof Feb. 3, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Grove Cemetery

Location Mount Grove Ind.

18. Funeral director Wm. J. Best & Sons

Address Boonsburg Ind.

19. Feb. 1, 1947 Blasf. Howard

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION About

20. DATE OF DEATH January 31, 1947 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____, and that I last saw him _____ alive on _____ 19____.

Immediate cause of death Acute coronary occlusion

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

Signature S. Robert Mello DEPUTY MEDICAL EXAM.

23. SIGNATURE _____ M. D. _____

Address Hagerstown, Md. Date signed 2/1/47

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FEB 4 1947
BUREAU

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00955

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
City or town Lappans - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 1
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Lappans - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro Md. R. 1
(If rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAME

Paul Edgar Smith

3. (b) Social Security Number

216-14-6588

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White married

8. (b) Name of husband or wife Mrs. Mary Smith

7. Birth date of deceased (mo., day, yr.) August - 28 - 1900
6. (c) If alive, give age 46 years

8. AGE: Years Months Days If less than one day
46 4 13 hrs. min.

9. Birthplace Tilghman Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Wash. Co. Road Dept.

12. Name Elia Smith

13. Birthplace Tilghman Wash. Co. Md.

14. Maiden name Laura Patterson

15. Birthplace Tilghman Wash. Co. Md.

16. Informant Mrs. Mary Smith

Address Boonsboro Md. R. 1

17. Burial Date thereof January - 15 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Lawn Cemetery

Location Williamsport Md.

18. Funeral director Wm. J. East & Sons

Address Boonsboro Md.

19. January 13 19 47 John H. East
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/47 19 47 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/11/47 19 47 to 1/11/47 19 47

and that I last saw him alive on 1/11/47 19 47

Immediate cause of death Rip & metastasis

DURATION

36 MO

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert F. Goring M. D. or other

Address Williamsport Md. Date signed 1/11/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Young

RECEIVED

JAN 15 1947

BUREAU V 8

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-4

CERTIFICATE OF DEATH

Reg. Dist. No. 3050

1. PLACE OF DEATH:

County... Washington
City or town... Bondules
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, institution, or street address where death occurred:
n. main st.
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
City or town... Bondules
(If outside city or town limits, write RURAL and give nearest town)
Street No... n. main st.
(If rural, give LOCATION)
2(a) If veteran, name war... none

3. (a) FULL NAME

John Luther Snively

3. (b) Social Security Number

none

4. Sex... male 5. Color or race... white 8. (a) Single, married, widowed, or divorced... widowed
6. (b) Name of husband or wife... Cora Cost Snively
7. Birth date of deceased (mo., day, yr.)... April - 9 - 1863
8. AGE: Years... 83 Months... 9 Days... 16 (c) If alive, give age... years...
...hrs. ...min.

9. Birthplace... Eakles Mills Wash. Co. Md.
(Town, county, and state)
10. Usual occupation... Express Messenger
11. Industry or business... Retired

12. Name... Washington Snively
13. Birthplace... Eakles Mills Wash. Co. Md.
14. Maiden name... Elizabeth Stank
15. Birthplace... Keedsville Wash. Co. Md.
16. Informant... Daniel W. Snively
Address... Keedsville Md.

17. Burial Date thereof... Jan 29 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory... Bondules Cemetery
Location... Bondules Md.
18. Funeral director... Wm F. Best & Son
Address... Bondules Md.

19. Jan 27 19 47 John H. Best
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 25 19 47 at... 5:45 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 10 19 47 to Jan 25 19 47
and that I last saw him alive on Jan 23 19 47
Immediate cause of death... Arteriosclerosis
not chronic nephritis
Due to... Chronic myocarditis
Duration... not stated
Other conditions...
(Include pregnancy within 3 months of death)

Major findings of operations...
Date of op. ...

Antopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE... John H. Best M. D. or other
Address... Bondules, Md. Date signed 1/27/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wade



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

00957

Reg. Dist. No.

3030

1. PLACE OF DEATH:

County Washington
 City or town Clear Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
35 Cumberland St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Clear Spring, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 35 Cumberland St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Cornelius K. Snyder

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Bessie G. Snyder
 6.(c) If alive, give age. years
 7. Birth date of deceased (mo., day, yr.) August 28, 1899
 8. AGE: Years 47 Months 4 Days 25 It less than one day hrs. min.

9. Birthplace Clear Spring Wash. Md.
 (Town, county, and state)
 10. Usual occupation Funeral Director
 11. Industry or business

FATHER 12. Name Leonard P. Snyder
 13. Birthplace Clear Spring, Md.
 MOTHER 14. Maiden name Elsie Kratz
 15. Birthplace Washington County, Md.

16. Informant Mrs. Bessie G. Snyder
 Address Clear Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 25, 1947
 (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Clear Spring, Md.

18. Funeral director Adrian H. Rowland
 Address Hagerstown, Md.

19. (Date rec'd by registrar) Jan 25 1947 Registrar Joseph W. Murray

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1947 at 10⁰⁰ P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 22 1947 to Jan. 22 1947
 and that I last saw him alive on Jan. 22 1947

Immediate cause of death CORONARY OCCLUSION
ACUTE SEVERE

DURATION

4 minute

Due to
 Due to

Other conditions None
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op.

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Arthur Robert Cohen M. D. & Officer
 Address Clear Spring Md Date signed 1-24-47

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JAN 29 1947

BUREAU 78

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00958

Reg. Diat. No.

302

1. PLACE OF DEATH:

County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 1 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Md. County... Wash.
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 36 N. Mulberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Donald Samuel Snyder, Jr.

3. (b) Social Security Number

--

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 12, 1946

8. AGE: Years 3 Months 6 Days 11 less than one day

9. Birthplace Hagerstown, Wash., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Donald S. Snyder, Sr.
13. Birthplace Hagerstown, Md.

MOTHER 14. Maiden name Catherine Marie Ketzel
15. Birthplace Hagerstown, Md.

16. Informant Mr. Donald S. Snyder, Sr.
Address Hagerstown, Md.

17. Burial Date thereof 1-20-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Hagerstown, Md.
Location

18. Funeral director Scott F. Minnich & Son
Address Hagerstown, Md.

19. Jan. 20, 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1947 at 8:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-14 1946 to 1-18 1947
and that I last saw him alive on 1-18 1947

Immediate cause of death Broncho pneumonia
DURATION 1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Maynard Bullwain M. D. or other

Address 135 N. POTOMAC Date signed 1-20-47

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1947

RECEIVED

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00959

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Potomac St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Elva Lee Snyder

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Divorced6.(b) Name of husband or wife... Joseph Grove I

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Nov. 8 18748. AGE: Years Months Days If less than one day
72 1 24 hrs. min.9. Birthplace... Williamsport, Md.
(Town, county, and state)10. Usual occupation... Housewife11. Industry or business... Home12. Name... Christian S. Snyder13. Birthplace... Williamsport, Md.14. Maiden name... Susan Conner15. Birthplace... Williamsport, Md.16. Informant... Herman K SnyderAddress... Williamsport, Md.17. Burial Date thereof... 1-3-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Riverview CemeteryLocation... Williamsport, Md.18. Funeral director... Edith V LeafAddress... #7 Church St. Williamsport, Md.19. Jan. 2, 47 Chas. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 12/25/46 19... of 2:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12/25/46 19... to 1/1/47 19...and that I last saw him alive on 1/1/47 19...Immediate cause of death... Notus Pneumonia

DURATION

5 Days

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

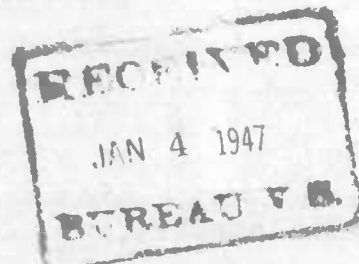
Means of injury Injured at work?

23. SIGNATURE... Chas. Bowers M.D. or otherAddress... Williamsport, Md. Date signed... 1/2/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3025

00960

926 ★

1. PLACE OF DEATH:

County Washington
 City or town Bridgeport, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 years
 Hospital, institution, or street address where death occurred:
Bridgeport, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Bridgeport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown, Md Route 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Elmer C. Stottlemeyer

3. (b) Social Security Number

212-10-6825

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Minerva Stottlemeyer
 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 4, 1877

8. AGE: Years 69 Months 10 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Myersville, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Retired Kiln Operator

11. Industry or business

12. Name Washington H. Stottlemeyer

13. Birthplace Myersville, Maryland

14. Maiden name Susan Hoover

15. Birthplace Myersville, Maryland

16. Informant Howard G. Stottlemeyer

Address Bridgeport, Maryland

17. Burial (Burial, cremation, or removal. Which?) 1-11-47
 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Jan. 11, 47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 47 7:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 40 to Jan. 9, 47
 and that I last saw him alive on Dec. 31, 46

Immediate cause of death Cerebral Hemorrhage DURATION 1/2 hr.

Due to Cerebral Hemorrhage 2-28-46

Due to Chronic Arteriosclerosis 40 yr

Other conditions Smoked Cigarettes

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results No Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Howard Yeager M. D. or other

Address Hagerstown, Md Date signed Jan. 9, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 14 1947

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1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00961

CERTIFICATE OF DEATH

Reg. Dist. No. 362

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
608 N. Mulberry St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 608 N. Mulberry St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ida Bertille Stouffer

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Charles M. Stouffer

7. Birth date of deceased (mo., day, yr.) July 7, 1873
 6. (c) If alive, give age. years

8. AGE: Years 73 Months 5 Days 28 If less than one day
 hrs. min.

9. Birthplace Washington Co. Md.
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

12. Name Henry M. Sickler13. Birthplace Washington Co. Md.14. Maiden name Catherine Gabrel15. Birthplace Washington Co. Md.16. Informant Edward R. StoufferAddress 610 N. Mulberry St. Hagerstown

17. Burial Date thereof Jan. 7, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadfording CemeteryLocation Near Cearfoss, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.

19. Jan 7, 47 Charles H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1947 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-47
1-5-47 19, to 19

and that I last saw h. alive on 19

Immediate cause of death

DURATION

Coronary occlusion 1/2/47

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stouffer M. D. or other

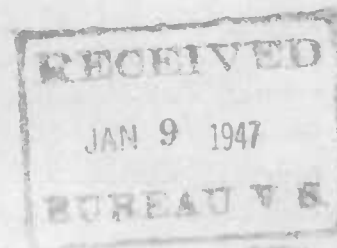
Jan 7, 47 Charles H. Bowers
 Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Layman

00962

Reg. Dist. No. 3030

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1603 Virginia Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

JAMES MONROE SWORD Jr.

3. (b) Social Security Number

215-09-7392

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Enna J. Sword

6. (c) If alive, give age 66 years
 7. Birth date of deceased (mo., day, yr.) October 30, 1879

8. AGE: Years 67 Months 2 Days 7 If less than one day
 --- hrs. --- min.

9. Birthplace Williamsport Washington Co., Md.
 (Town, county, and state)

10. Usual occupation Leather Splitter11. Industry or business Byron Tannery12. Name James Monroe Sword13. Birthplace Williamsport Md.14. Maiden name Mary E. McClain15. Birthplace Williamsport Md.16. Informant Mrs. Enna SwordAddress Hagerstown Md.

17. Burial Date thereof 1/9/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory River View CemeteryLocation Williamsport Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Jan. 9, 47 Shaeff/Boovers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1947 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 to Jan 7 1947
 and that I last saw him alive on Jan 6 1947

Immediate cause of death Carcinoma of stomach
probable metastasis to
 Due to infection

Due to

Other conditions Colostomy
Removal of gallbladder
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Layman M. D. or other

Address 100 Professional Bldg. Hagerstown Md.
Jan 7 1947
 Date signed

RECEIVED
JAN 11 1947
BUREAU 3

1-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159 00963
★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 437 Ridge Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Paula Jean Toms

3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife None
 6.(c) If alive, give age --- years
 7. Birth date of deceased (mo., day, yr.) January 2 1947
 8. AGE: Years - Months - Days 3 If less than one day --- hrs. --- min.

9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Infant
 11. Industry or business ---

12. Name Bernard Toms
 13. Birthplace Garfield Md.
 14. Maiden name Marylin Kennedy
 15. Birthplace Cumberland Md.
 16. Informant Bernard Toms
 Address Hagerstown Md.

17. Burial Date thereof 1/6/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Jan. 6, 1947 Charles H. Bever
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1947 19 5 at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1947 to January 5, 1947
 and that I last saw him er alive on January 5, 1947

Immediate cause of death Prematurity
(23 months term)

DURATION

Due to ---Due to ---Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE B. Kneisley M. D. or otherAddress Hagerstown Md. Date signed 1-6-47

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BUREAU VS

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-2

CERTIFICATE OF DEATH

Reg. Dist. No. 3820

1. PLACE OF DEATH:

County WASHINGTON
City or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LIFEHospital, institution, or street address where death occurred:
WASHINGTON COUNTY HOSPITALHow long in hospital or institution? 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTONCity or town HAGERSTOWN, HALFWAY
(If outside city or town limits, write RURAL and give nearest town)Street No. 2207 VIRGINIA AVE.
(If rural, give LOCATION)2. (a) If veteran, name war NON-VET

3. (a) FULL NAME

IDA ELLNORA TRONE

3. (b) Social Security Number

1212-14-6329

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

8. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 21, 18648. AGE: Years 82 Months 11 Days 6 hrs. min.9. Birthplace ROXBURY, WASHINGTON, MD.
(Town, county, and state)10. Usual occupation SALES LADY11. Industry or business DEPT. STORE12. Name LEWIS TRONE13. Birthplace GERMANY14. Maiden name SUSAN HISE15. Birthplace LANCASTER, PA.16. Informant Miss Clara Jane Trone SisterAddress 2207 Virginia Ave Hagerstown Md17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan. 30, 1947
(month) (day) (year)Cemetery or crematory Funkstown CemeteryLocation Funkstown Md.18. Funeral director Woodford J. NormanAddress Hagerstown Md.19. Date rec'd by registrar Jan. 28, 47 Registrar Chas H Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27/47 1947 at 2:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/19/47 1947 to 1/27/47 1947and that I last saw her alive on 1/27/47 1947Immediate cause of death neumonia DURATION 3 DaysDue to Frac. neck Rt. Lumer 10 DaysDue to Accidental fall - fell down stairs cuca

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of January 28, 1947Where did injury occur? Hagerstown Washington Maryland
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury Accidental fall Injured at work?23. SIGNATURE Ralph F. Jones M. D. or otherAddress Williamson & Jones Date signed 1/29/47

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BUREAU

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Evidence for the change of
age is shown on
G 108 1/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

00965

Reg. Dist. No. 3025

1. PLACE OF DEATH:

County Washington
City or town Security
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 minutes
Hospital, institution, or street address where death occurred:
North American Cement Co.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
City or town Security
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
World War II
2.(a) If veteran, name war.

3. (a) FULL NAME

Riley O. Williams

3. (b) Social Security Number

219-12-1291

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Pauline I. Williams

6. (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) October 14, 1925

8. AGE: Years 22 Months 2 Days 19 If less than one day
.....hrs.min.

9. Birthplace Security Wash. Md.
(Town, county, and state)

10. Usual occupation Griffin miller

11. Industry or business North American Cement Co.

12. Name Richard S. Williams

13. Birthplace Security Md.

14. Maiden name Merle R. Godlove

15. Birthplace Wardensville W. Va.

16. Informant Mrs. Richard S. Williams

Address Security Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 6, 1947
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. Jan. 5, 1947 Blackbourn
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1947 at 7:20a M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....19....., to.....19.....
and that I last saw him.....alive on.....19.....

Immediate cause of death.....
Open fracture of right humerus

Due to Open fracture of skull
Hemorrhage and shock

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....None.....Date of op.....

Autopsy results.....None.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1/3/47

Where did injury occur? Security Wash. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) North American Cement Corp.

Means of injury Caught in belt Injured at work? Yes

23. SIGNATURE J. Robert Walls DEPUTY MEDICAL EXAM.
M.D. CO. MD.

Address Hagerstown, Md. Date signed 1/3/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 7 1947

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1-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00966

155

Reg. Dist. No. 302

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>40 years</u> Hospital, institution, or street address where death occurred: <u>Washington County Hospital</u> How long in hospital or institution?..... <u>1 day</u>	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>300 Vine St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....
---	---

3. (a) FULL NAME <u>Cora L. Wilson</u>	3. (b) Social Security Number -----
--	---

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Widowed</u>
6.(b) Name of husband or wife..... <u>David L. Wilson</u>		

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) February 15, 1886

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>1</u>	<u>10</u>	<u>18</u>
			hrs.	min.

9. Birthplace..... Richmond Va.
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business..... Unknown

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Manda Bonds

15. Birthplace..... Unknown

16. Informant..... Charles Wilson

Address..... Hagerstown Md.

17. Burial..... 1-6-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown Md.

18. Funeral director..... Scott F. Minnich & Son

Address..... Hagerstown Md.

19. Jan. 6, 1947 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION
 20. DATE OF DEATH..... January 3, 1947, 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 2, 1947, to Jan 3, 1947

and that I last saw her alive on Jan 3, 1947

Immediate cause of death..... Perforated Peritonitis

DURATION..... 2 days

Due to..... Perforated gastric ulcer

Due to..... 6 mos

Other conditions..... Pulmonary Tuberculosis

Bilateral

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert H. Campbell M.D.

Address..... 145 W. Washington St. Date signed..... Jan 4/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

00967

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
 460 Park Place
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 460 Park Place
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Harry Clifford Wilson

3. (b) Social Security Number

214-09-6764

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mollie Wilson
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb 5th, 1881
 8. AGE: Years 65 Months 11 Days 6 It less than one day hrs. min.

9. Birthplace Washington County, Md.
 (Town, county, and state)

10. Usual occupation Fairchilds Air Craft Co

11. Industry or business

FATHER 12. Name William Wilson
 13. Birthplace West Virginia

MOTHER 14. Maiden name Annie
 15. Birthplace West Virginia

16. Informant Mrs. Harry C. Wilson
 Address 460 Park Place Hagerstown, Md.

17. Burial Date thereof Jan. 13, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. Jan. 13, 47 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1947, at 5:45 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 18, 1940, to Jan. 11, 1947
 and that I last saw him alive on Jan. 11, 1947

Immediate cause of death Acute cerebral hemorrhage
 DURATION

Due to
 Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert + Wells M.D.

Address Hagerstown, Md. Date signed 12/11/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 15 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3057

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Bonsubro</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Life</u> Hospital, institution, or street address where death occurred <u>n. main St.</u> How long in hospital or institution? <u>at home</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Bonsubro</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>n. main St.</u> (If rural, give LOCATION) 2(a) If veteran, name war <u>none</u>			
3. (a) FULL NAME <u>Georgia Wise</u>				3. (b) Social Security Number <u>none</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>married</u>		MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Jan 11</u> 19 <u>47</u> at <u>2 A</u> M 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from19....., to19..... and that I last saw h.....alive on19..... Immediate cause of death..... <u>Acute coronary occlusion</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op. Autopsy results..... <u>No</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.	
6. (b) Name of husband or wife <u>Wm. Wise</u>							
7. Birth date of deceased (mo., day, yr.) <u>December -28- 1864</u>							
8. AGE: Years <u>82</u> Months <u>0</u> Days <u>13</u> If less than one dayhrs.min.							
9. Birthplace <u>near Bonsubro Wash. Co. Md.</u> (Town, county, and state)							
10. Usual occupation <u>Housewife</u>							
11. Industry or business <u>Own Home</u>							
FATHER	12. Name <u>Charles Long</u>					MOTHER	
	13. Birthplace <u>Wash. Co. Md.</u>						
FATHER	14. Maiden name <u>Margaret Knodel</u>					MOTHER	
	15. Birthplace <u>Wash. Co. Md.</u>						
18. Informant <u>Wm. Wise</u> Address <u>Bonsubro Md.</u>							
17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>January 13, 1947</u> (month) (day) (year) Cemetery or crematory <u>Bonsubro Cemetery</u> Location <u>Bonsubro Md.</u>							
18. Funeral director <u>Wm. J. Bart & Sons</u> Address <u>Bonsubro Md.</u>							
19. Date rec'd by registrar <u>Jan 13</u> 19 <u>47</u> <u>John B. Bart</u> Registrar							
23. SIGNATURE <u>S. Robert Wells</u> Address <u>Hagerstown Md</u> Date signed <u>Jan 12/47</u>							

DEPUTY MEDICAL EXAM.

M. D. or

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JAN 15 1947
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00969

Reg. Dist. No. 3120

1. PLACE OF DEATH: County <u>Washington</u> <u>Hagerstown</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 days</u> Hospital, institution, or street address where death occurred <u>Washington County Hospital</u> How long in hospital or institution? <u>2 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> <u>Hagerstown</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>139 E. Baltimore St.</u> (If rural, give LOCATION) 2. (a) If veteran, name war _____	
3. (a) FULL NAME <u>Edith L. Wolfinger</u>		3. (b) Social Security Number -----	
MEDICAL CERTIFICATION			
4. Sex <u>Female</u>		5. Color or race <u>White</u>	
6. (a) Single, married, widowed, or divorced <u>Married</u>		2D. DATE OF DEATH <u>January 30</u> 19 <u>47</u> at <u>6:25a</u> M	
6. (b) Name of husband or wife <u>Marshall A. Wolfinger</u>		21. I certify that death occurred on the date above stated; that I attended deceased from <u>January 3</u> 19 <u>47</u> , to <u>January 30</u> 19 <u>47</u> and that I last saw him alive on <u>January 30</u> 19 <u>47</u>	
6. (c) If alive, give age <u>59</u> years		Immediate cause of death <u>Cerebral Hemorrhage</u>	
7. Birth date of deceased (mo., day, yr.) <u>October 23, 1887</u>		DURATION <u>2 days</u>	
8. AGE: Years <u>59</u> Months <u>3</u> Days <u>7</u> If less than one day _____ hrs. _____ min.		Due to <u>Hypertensive Vascular Disease</u>	
9. Birthplace <u>Hagerstown Wash. Md.</u> (Town, county, and state)		Due to _____	
10. Usual occupation <u>House Wife</u>		Other conditions <u>Hypertensive Heart Disease with heart failure</u> (Include pregnancy within 3 months of death)	
11. Industry or business <u>Own Home</u>		Major findings of operations _____	
12. Name <u>Charles A. Maisack</u>		Date of op. _____	
13. Birthplace <u>Hagerstown Md.</u>		Autopsy results _____	
14. Maiden name <u>Lula M. Harris</u>		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
15. Birthplace <u>Hagerstown Md.</u>		22. VIOLENCE: If death was due to external causes, fill in the following:	
16. Informant <u>Marshall A. Wolfinger</u>		Accident, suicide, or homicide _____ Date of _____	
Address <u>Hagerstown Md.</u>		Where did injury occur? _____ (City or town) _____ (County) _____ (State)	
17. Burial (Burial, cremation, or removal. Which?) _____ Date thereof <u>2-1-47</u> (month) (day) (year)		Injured at home, farm, industry, public place (where?) _____	
Cemetery or crematory <u>Rose Hill Cemetery</u>		Means of injury _____ Injured at work? _____	
Location <u>Hagerstown Md.</u>		23. SIGNATURE <u>Salton M. Welty, M.D.</u> M.D. or other _____	
18. Funeral director <u>Scott F. Minnich & Son</u>		Address <u>998 Potomac Ave., Hagerstown</u>	
Address <u>Hagerstown Md.</u>		Date signed <u>1-31-47</u>	
19. Feb. 1, 47 (Date rec'd by registrar)		Registrar <u>Chas. H. Powers</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Pooler 175

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Months
 Hospital, institution, or street address where death occurred:
818 Concord St.
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 818 Concord St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

RALPH WOOD

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Addie Lee
 6. (c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) February 28, 1885
 8. AGE: Years 61 Months 11 Days 17 If less than one day --- hrs. --- min.

9. Birthplace Danville Vermilion Co. Ill.
 (Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business Retired

12. Name Frank Wood

13. Birthplace Danville Ill.

14. Maiden name Ella Stewart

15. Birthplace Danville Ill.

16. Informant Mrs. M. C. Kunnert

Address Hagerstown Md.

17. Burial Date thereat 1/18/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Jan. 18, 1947 Registrar Charles Howard
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1947 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 12, 1947 to Jan. 15, 1947 and that I last saw him alive on Jan. 14, 1947.

Immediate cause of death
Cerebral Hemorrhage
Hemiplegia (Right)
(Second time)
 Due to Diabetes Mellitus
1939.
 Due to Cerebral Hemorrhage
1939.
 Other conditions Right Hemiplegia
 (Include pregnancy within 3 months of death)

DURATION

4 days4 "3 yrs.2 yrs.

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest H. Pooler, M.D.
 M. D. or other

Address Hagerstown, Md. Date signed 1/16/47

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